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Policy Conditions 2019
VGZ Eigen Keuze

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Important information

Mijn Aevitae
With My Aevitae, you can change your policy and check the status of your expense forms.
Log in at www.aevitae.com or use the Aevitae Zorg App and discover the possibilities!

Contact:
Check our contact information in these policy conditions or go to https://www3.aevitae.com/contact/.

Contracted healthcare
Please find our contracted healthcare providers at https://www3.aevitae.com/zoek-vgz-zorgverlener/.

Requesting approval
If you would like to know which healthcare services and treatments are subject to our prior approval, please check our policy conditions. Would you like to request our approval? Download the approval application form at https://www3.aevitae.com/zorgverzekeringen/documenten/. Please print, complete or have completed, sign and send the form to:
Aevitae
t.a.v. Medische Garanties
Postbus 2705
6401 DE Heerlen

Easy online expense forms
It is easy to submit expense forms online through My Aevitae. Logging in is secure using your username, password and SMS verification code. If you prefer submitting expense forms by post, please send the original invoice and the expense form to:
Aevitae
t.a.v. Declaratieverwerking
Postbus 2705
6401 DE Heerlen

I General Section

Article 1 Covered healthcare

1.1. Contents and scope of covered healthcare

VGZ Eigen Keuze is an in-kind policy of the healthcare insurer, further referred to as 'the healthcare policy'. Pursuant to this healthcare policy, you are entitled to healthcare in kind as set out in these policy conditions. You are also entitled to healthcare advice and healthcare mediation.

> Healthcare advice and mediation
> Our Healthcare Advice and Mediation department advises you about the healthcare provider you can consider for your healthcare issue. Please also contact our Healthcare Advice and Mediation department if you are confronted with a non-acceptable long waiting list for visiting a policlinic or for hospitalisation, for example. You can reach this department through our website.

Medical necessity

You are entitled to (reimbursement of the cost of) healthcare as set out in these policy conditions if you are in reasonableness relying on the relevant form and content of healthcare, provided that the form of healthcare is effective and efficient. A key factor in the content and scope of the healthcare form is 'what the relevant healthcare providers generally offer'. Other factors in the content and scope of the healthcare are the status of science and medical practice. This is determined using the Evidence-Based Medicine (EBM) method. If information on the state of science and practice is not available, the content and form of the healthcare are determined by what is regarded in the relevant discipline as responsible and adequate care.

1.2 Who may provide healthcare

Your healthcare provider must comply with certain conditions. The relevant healthcare provision sets out which healthcare providers may provide the healthcare services and the supplementary conditions the healthcare provider must fulfil. If the healthcare provider does not comply with the conditions imposed, then you are not entitled to reimbursement of the cost.

1.3. Healthcare provided by a contracted healthcare provider

The care in kind will be given by a healthcare provider that we concluded an agreement with for the relevant healthcare: a contracted healthcare provider. An overview of contracted healthcare providers is also available from our website, including the healthcare services they can and cannot provide pursuant to their contract with us. The healthcare provider receives the fee for the healthcare provided from us directly. This is based on the rate agreed with the relevant healthcare provider.

> We make agreements with healthcare providers on the quality, price and service of the healthcare to be delivered. Your interests are our number one priority. And if you select a contracted healthcare provider, this will make a difference in costs for you and us. If you selected a healthcare provider that we have not contracted for the relevant care, then please take into consideration that you will likely have to pay part of the bill yourself.

1.4. Healthcare provided by a non-contracted healthcare provider

If you selected a healthcare provider we have not contracted for the relevant care, then part of the bill total may be charged to you. The cost of the (covered) healthcare will be reimbursed up to 80% of the average rates as agreed with the relevant healthcare providers for the relevant forms of healthcare ('average contracted rates'). If no rates were agreed with healthcare providers for the relevant healthcare and Wmg (Healthcare Market Organisation Act) rates apply, the costs are reimbursed up to 80% of the Wmg rates. Part of the bill total may then be charged to you.

General practitioner care

Do you use general practitioner care as set out in Article 11, General practitioner care items 1, 2 and 3.1 at a general practitioner or healthcare group that we have not concluded a contract with for such healthcare? Then you are entitled to reimbursement of the cost of healthcare up to a maximum of the applicable Wmg rates (Market Regulation Healthcare Act (Wmg Act)). We reimburse the cost of tests requested by your general practitioner to be carried out by another non-contracted healthcare provider (for example X-rays or blood tests) up to a maximum of 80% of the average contracted rate.

Please find the maximum reimbursements in the 'List of maximum reimbursements non-contracted healthcare providers'. This list is available from our website. The maximum reimbursements were determined without factoring in your excess or personal contribution. These amounts will be set off against the maximum reimbursement.

If there is a case of acute care that is provided by a non-contracted healthcare provider, you are entitled to reimbursement of the costs up to the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands. Please inform us about such healthcare as soon as possible.

1.5 Sending invoices

Most healthcare providers send us their invoices directly. If you receive an invoice at home, please complete an expense form and submit it together with the original invoice. Please do not send us a copy or a reminder. We can only process originals. You may submit invoices latest up to three years after the start of your treatment.

Please check that the following details are listed in the invoice:
- your name, address and date of birth;
- type of treatment, the amount per treatment and the date of treatment;
- the name and address of the healthcare provider.

These invoices have to be specified, ensuring that the reimbursements we must pay out can be derived from the specifications directly and without any ambiguity. We deduct any excess and statutory personal contribution from the reimbursement. Forconversion of foreign invoices in currencies other than euros, we use the historical rates available from www.xe.com. This is based on the exchange rate on the date of treatment. Invoices must be in Dutch, English, French, German or Spanish. If a translation is necessary to our discretion, we may request you to provide a certified translation of the invoice. We will not refund the translation expenses.

Online expense forms
Online submission of expense forms is quick and easy. Go to the My aevitae. You must retain the original invoice for at least one year after submitting the relevant claim form. We may request the invoices for inspection. If you are unable to submit the invoices, we may recover the amounts paid out from you, or settle the relevant amounts with amounts due to you.

1.6 Temporary healthcare provision

If a contracted healthcare provider is unable to deliver the relevant service or treatment at all or in time, you are entitled to healthcare mediation. We may grant approval to see a non-contracted healthcare provider for the relevant healthcare. In such cases we reimburse the costs up to the statutory Wmg rates. If no Wmg rates have been determined, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands. To determine if healthcare was provided in due time, we take into consideration:
- specific medical factors;
- general, socially acceptable waiting lists based on psychological, social and ethical factors.

1.7 Direct payment

We reserve the right to directly pay the healthcare costs to the healthcare provider. This payment voids your right to reimbursement.

1.8. Settlement of costs

If we pay costs directly to the healthcare provider and we reimburse an amount higher than our contractual obligation pursuant to your healthcare insurance policy, or the costs of the relevant healthcare services are otherwise charged to you, the relevant excess amount is charged to you as the policyholder. We will charge these amounts to you at a later stage. You have a legal obligation to pay such amounts. We reserve the right to settle such amounts with amounts due to you.

1.9. Referral, prescription or approval

For some types of healthcare, you require a referral, prescription and/or prior approval in writing demonstrating that you are dependent on this healthcare. Details are set out in the relevant healthcare article. A prior referral, prescription and/or approval is not required for emergency healthcare, i.e. healthcare that cannot reasonably be postponed.

Referral or prescription
Does the healthcare article set out that you require a referral or a prescription? Then you can request one from the relevant healthcare provider referred to in the Article. This is generally the general practitioner.

Approval
In some cases you also require our permission prior to receiving the healthcare. This permission is referred to as prior approval. If you have not obtained prior approval where required, then you are not entitled to healthcare or to reimbursement of the cost of the relevant healthcare.

If you selected a healthcare provider that we have contracted for the relevant care, you do not require prior approval. Your healthcare provider will in such cases assess if you fulfil the conditions and/or requests approval from us on your behalf. A list of our contracted healthcare providers is available from our website. Alternatively, you may submit a request for approval to us. Please find our address on the cover sheet of the conditions.

If you selected a healthcare provider we have not contracted for the relevant care, Then you need to personally submit the request for approval to us.

If you have approval for insured healthcare, this also applies if you transfer to a different healthcare insurer or if you received approval from your previous insurer.

1.10. When are you entitled to (reimbursement of the cost of) covered healthcare?

You are entitled to healthcare or reimbursement of such healthcare if the healthcare was delivered during the term of your healthcare insurance policy. Should these Policy Conditions refer to a year or calendar year, the actual date of treatment or date on which services/goods were provided as stated by the healthcare provider will determine the year or calendar year to which the relevant costs should be allocated. If a treatment falls in two calendar years and the healthcare provider may charge the cost as a single amount (for example a Diagnosis and Treatment Combination), we will reimburse these costs if the treatment was started within the term of the insurance policy and the cost will be allocated to the calendar year of the first treatment.

1.11. Exclusions

You are not entitled to:

- types of healthcare or healthcare services that are funded pursuant to legal regulations, including the Wlz (Long-Term Healthcare Act), the Youth Act or the 2015 Wmo (Social Support Act);
- reimbursement of personal contributions or excess payable under the terms of the healthcare insurance, except if and where these policy conditions determine otherwise;
- reimbursement of fees for not appearing at your appointment with a healthcare provider (the 'no-show fee');
- reimbursement of fees for written statements, mediation fees charged by third parties without our prior approval in writing, administrative fees or charges incurred by past-due payment of invoices from healthcare providers;
- reimbursement of losses that are an indirect result of our actions or omissions;
- healthcare and reimbursement of healthcare costs caused by or resulting from armed conflict, civil war, uprising, civil disorder, riots or mutiny occurring in the Netherlands, as defined in Section 3.38 of the Wet op het financieel toezicht (Financial Supervision Act);

1.12. Right to care and other services as a result of terrorist acts

If you need healthcare as a result of one or more terrorist events, then the following rule applies. If the total amount of claims submitted within a year or calendar year for non-life, life or in-kind funeral insurers (including healthcare insurers) according to the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT or Dutch Reinsurance Company for Terrorism-Related Claims) exceeds the maximum amount that this company reinsures annually, you are entitled to only a certain percentage of the cost or value of the healthcare. The NHT determines the exact percentage. This applies for non-life, life and funeral insurers (including healthcare insurers) that are subject to the Financial Supervision Act. The exact definitions and provisions for the above-mentioned entitlement are included in NHT's Clauses Sheet Terrorism Cover.

If after a terrorist act an additional amount is provided under Section 33 of the Zorgverzekeringswet (Healthcare Insurance Act) or Section 2.3 of the Besluit Zorgverzekering (Healthcare Insurance Decree), you are entitled to an additional scheme as set out in Section 33 of the Healthcare Insurance Act or Section 2.3 of the Healthcare Insurance Decree.

Guarantee pay-out on terrorism-related claims

In order to be able to guarantee that you will receive payment on terrorism-related claims, (almost all) insurers in the Netherlands are party to NHT (the Dutch Reinsurance Company for Terrorism-Related Claims). We are also a member. The NHT issued regulations that ensure pay-out of at least part of any terrorism-related claim.
The NHT has set a maximum to the total amount to be paid out relating to terrorist actions. The maximum amounts to 1 billion euros per year for all insured together. If the total claim amount is higher, each insured that submitted a claim will receive pay-out at an equal percentage of the maximum amount. NHT set out the rules for due processing of loss claims in the Protocol for Processing Claims.
In reality, this may mean you are not paid out the full amount claimed. However, you are at least assured that you will receive payment of at least part of your claim.

Article 2 General provisions

2.1. Basis and contents of the healthcare insurance

The insurance contract was concluded based on the details you submitted in the application form or in writing. After taking out the healthcare insurance policy, you will receive a healthcare policy from us as soon as possible. Furthermore, you will receive a new healthcare policy prior to each new calendar year.
These policy conditions form an integral part of the healthcare policy. The policy cover will state the persons insured and the healthcare insurance taken out for them.

2.2. Scope of application

The healthcare policy is available to all persons subject to mandatory insurance, residing either in the Netherlands or abroad.

> The healthcare insurer operates throughout the Netherlands. If you are subject to mandatory insurance, you may continue this healthcare policy. Persons subject to mandatory insurance residing abroad are also entitled to concluding this insurance.

2.3. Corresponding documents

These policy conditions refer to documents. These documents are part of the conditions. It concerns the following documents:

- Appendix 1 to the Healthcare Insurance Decree
- Clauses Sheet Terrorism Cover
- Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care); List maximum reimbursements non-contracted healthcare providers
- List GGZ Therapies (Mental Healthcare)
- Limitative list of DBCs (Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland (Healthcare Insurers Netherlands) to be requested in advance;
- Overview of contracted healthcare providers;
- Premium Appendix;
- Healthcare Insurance Scheme;
- Pharmaceutical Care Regulations;
- Medical Aids Regulations;
- Nursing and care personal budget regulations;
- Reference guide assessment plastic surgery treatments;
- Healthcare Module Prevention Diabetic Foot Ulcers;
- Standard of care for Obesity.

You can find these documents on our website. Alternatively, you may request these documents from our customer service desk.

2.4. Fraud

Fraud (full or partial) will result in claims not being paid out, and/or recovery of claims already paid out. If you commit fraud, your entitlement to healthcare or reimbursement of healthcare costs lapses. We will claim any amounts paid out from you in a recovery process. You will also be charged the cost ensuing from the fraud audit/inspections.

Reporting and registration

In the event of fraud, we reserve the right to report the event to the police. Additionally, we may have your information and details of the co-perpetrators and accessories registered:

- in our Incident Register;
- in Centrum Bestrijding Verzekeringsfraude (CBV or Centre for Countering Insurance Fraud) of Verbond van Verzekeraars (VvV or Dutch Association of Insurers);
- in the external referral register of the CIS foundation (Stichting Centraal Informatiesysteem or Foundation Central Information System).

Termination of insurance policy/policies

If you commit fraud, we will terminate your healthcare insurance policy. In that event, you will not be accepted for a new healthcare insurance policy for 5 years. We will also terminate your supplementary insurance. In that event, any applications for supplementary insurance will be rejected for a period of 8 years by any insurer that is a member of Coöperatie VGZ.

2.5. Private data protection

We process your private data when we carry out your insurance policies. This is completed in compliance with legislation and regulations, including the General Data Protection Regulation (GDPR). Please find more details about this in the privacy statement on our website. The privacy statement also states your rights. If you have any questions regarding processing private data, please contact our Data Protection Officer. For more information about privacy, please check the Privacy page on our website.

> Confidentiality of your address
> In the implementation of your insurance policy, we reserve the right to share your address with parties such as healthcare providers. If you wish to keep your address confidential, please contact us. In that case we will not share your address with any other parties.

2.6. Notifications

Any notifications sent to the most recent address in our system are deemed to have reached you. If you want to receive all our messages in electronic format, please indicate your choice in the My Aevitae.

2.7. Membership of Coöperatie VGZ

Upon acceptance to this healthcare insurance policy, you, as the policyholder, also become a member of the cooperative society Coöperatie VGZ U.A., unless you notify us in writing that you do not wish to do so. This Coöperatie represents the interests of its members in the field of healthcare or other insurance. You may terminate your membership at any time, subject to a one-month notice period. The membership will in any case be terminated on the termination date of the insurance contract.

2.8. Cooling-off period

Upon taking out your healthcare insurance policy, you have a 14-day cooling-off period as the policyholder. You are entitled to cancel the insurance policy in writing within 14 days of signing the contract. In that event the insurance contract is deemed to have never been concluded.

2.9. Prioritisation

Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Healthcare Insurance Act have or ought to have an effect on the healthcare policy, these will be deemed to form an integral part of these policy conditions. Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Healthcare Insurance Act are conflicting with the provisions of this contract, the provisions of the Healthcare Insurance Act will be leading, followed by the provisions of Title 7.17 of the Dutch Civil Code, followed by the provisions of this healthcare insurance.

2.10. Dutch law

This healthcare insurance is governed by Dutch law.

Article 3 Premium

3.1. Premium base and premium discounts

The premium base is the premium without premium discount for any voluntary excess and/or discount as agreed in a group contract. The premium base and the premium discount for voluntary excess is set out in the premium appendix as amended annually. Please find this premium appendix on our website.

The premium base and premium discounts applicable to you are set out in your policy cover.

3.2. Premium discount for group contract

3.2.1. If you participate in a group contract, you will receive a discount on the premium base.

3.2.2. The premium discount and conditions as set out in the group contract will lapse on the date you can no longer participate in the group contract. From this date onwards, the healthcare insurance is continued on an individual basis.

3.2.3. You may not participate in more than one group contract at the same time.

3.3. Who pays the premium?

The policyholder has the obligation to pay premiums. No premium is due for an insured person under age 18 until the first day of the calendar month following the person's 18th birthday. Upon death of an insured, premium is due only up to the date of death. After a change of the insurance policy, we will recalculate the premium as per the effective date of the change.

Example
Someone who turns 18 on 1 July pays premium commencing on 1 August.

3.4. Payment of premium, statutory contributions, excess and costs

3.4.1. Payment of the premium and domestic and/or foreign statutory contributions must be pre-paid for all insured in advance, unless agreed otherwise. If you pay an annual premium in advance, you will receive a payment discount on the premium due. The amount of the discount is stated on the policy cover.

3.4.2. You pay the premium, excess, personal contributions and any reimbursement amounts paid out to you unjustified in the payment method as agreed with us.

Payment options free of charge

a. You authorise us for automatic direct debit of the amounts due (see also Article 3.4.3).
b. We will mail you a bank giro for each payment term.
c. Your employer withholds the premium from your salary and transfers it to us. This payment option only applies to the premium.

No extra fees are charged for the above payment options.

3.4.3. Your authorisation for direct debit is valid for payment of the premium, the excess, personal contributions and any reimbursement amounts paid out to you unjustified. Such an authorisation applies during and if necessary after expiration of the insurance contract. Please refer to your policy schedule to check the date of direct debit collection of the premium for the entire calendar year. For the other costs, we will notify you at least 3 days before the date on which the amount is collected, stating the amount to be taken out of your account and the direct debit transaction date. If you disagree with a processed payment, you can have the payment reversed later. Please contact your bank within 8 weeks of processing the payment. The monthly amount to be automatically collected for your excess, personal contributions and any reimbursement amounts paid out to you unjustified is capped at €220 per month. For any amounts exceeding €220, you will receive a paper invoice. If we choose to send you a paper invoice, this form of payment is free of charge for you.

3.5. Settlement

You may not settle any amounts due with any amounts payable to you.

3.6. Overdue payments

3.6.1. If you do not pay the premium, statutory contributions, personal contributions, the excess and any reimbursement amounts paid out unjustified in due time, we will send you a reminder. If you do not pay within the period of at least 14 days as specified in the reminder, we may decide to suspend cover of this healthcare insurance policy. In that case you are not entitled to healthcare and reimbursement of healthcare costs from the last premium due date before the reminder. Your obligation to pay the premium will continue during any period of suspension. Entitlement to (reimbursement of the cost of) healthcare is restored on the date following the date on which the amount due plus any fees were received. We reserve the right to terminate the healthcare insurance policy if payments are in arrears. The insurance will not be terminated with retroactive effect in that case.

3.6.2. We may charge the following fees in the event of overdue payment:

- statutory interest from the day following the due date of the original invoice;
- debt collection fees from the day following the due date of the original invoice.

3.6.3. If you have received a reminder for overdue payment of premiums, statutory contributions, excess, personal contributions or reimbursements paid out to you that prove unjustified, then we do not have a legal obligation to send you a separate written reminder if payment for the subsequent invoice is overdue.

3.6.4. We reserve the right to settle any arrears in premiums, costs and statutory interest due with any healthcare expense forms or other amounts payable to you.

3.6.5. If we terminate the healthcare insurance policy due to overdue payment of the premium, we reserve the right to reject any applications from you for insurance contracts for five years.

3.6.6. Consequences of non-payment of two monthly premiums or more

a. If you have payment arrears amounting to two monthly premiums, we offer you as policyholder a payment schedule. We will give you 4 weeks to decide to accept our offer for a payment schedule. We will also inform you relating to the consequences of non-acceptance of our offer and your arrears run up to 6 or more monthly premiums.
b. If you have payment arrears amounting to four monthly premiums, you will receive a warning that we will register you with the CAK for the defaulters scheme once the payment arrears amount to six monthly premiums, unless we conclude a payment scheme with you after all.

c. If you as policyholder have payment arrears amounting to 6 monthly premiums or more, we will register you with the CAK for the defaulters scheme and you will be obliged to pay the CAK an administrative premium. For the period you owe the CAK an administrative premium, you will not owe us any premium. The administrative premium to the CAK is higher than the premium you would normally pay us.

If you have other insured on your policy and payment arrears arose for them, they will receive copies of our messages to you about the premium arrears.

You can read the consequences of non-payment of the premium and the administrative premium in Sections 18a to 18g of the Healthcare Insurance Act.

3.6.7. You are not liable for paying premiums to us on the period as referred to in Section 18e of the Healthcare Insurance Act.

Article 4 Other obligations

You have the following obligations:

- to inform us of any facts that mean (or could mean) that expenses may be recovered from third parties with actual or potential liability, and to provide us with the necessary information in this context. You may not make any arrangements with a third party without our prior approval in writing. You must refrain from any actions that may harm our interests;
- to cooperate with our medical advisor or employees in order to obtain all information required for (inspection of) the actual execution of the healthcare insurance cover;
- to ask the healthcare provider to disclose the reason for hospitalisation to our medical advisor;
- you must report any facts and conditions that may be relevant to correct execution of the insurance policy as soon as possible. This includes end of mandatory insurance, start and end of detention, separation or divorce, birth, adoption, or a change in bank or giro account number. We are not liable for any risks in the event of non-compliance with the above provisions.

If you fail to fulfil your obligations and this harms our interests, we reserve the right to suspend your right to (reimbursement of the costs of) the covered healthcare.

Article 5 Change in the premium or premium base and conditions

5.1. Change in conditions

We reserve the right to change the conditions and the premium or premium base of the insurance policy at any time. We will inform you, the policyholder, in writing accordingly. A change in the premium base will only become effective 7 weeks after the date on which you were notified of such change. A change in the conditions will only become effective one month after the date on which you were notified of such change.

5.2. Cancellation right

If we change any conditions and/or the premium base of the healthcare insurance policy to your disadvantage, you, as the policyholder, have the right to cancel the insurance contract as per the effective date of the change. You may cancel the contract in any case during one month after being notified of the amendment. However, you do not have this right to give notice if a change in the insured healthcare cover results directly from amendment of the provisions set out in Sections 11 through 14a of the Health Insurance Act.

Article 6 Start date, term and termination of healthcare cover

6.1. Start date and term

6.1.1. The insurance contract becomes effective on the date on which we receive your application or application form. You will receive a confirmation of receipt stating the date on which we received your application. If you are subject to mandatory insurance and you do not yet have a BSN (citizen service number), you can still be registered as an insured.

6.1.2. Sometimes we are unable to derive from the application whether or not concluding a healthcare policy with the person to be insured is mandatory for us. In such cases we will request information from you that would prove that concluding a healthcare policy with you is mandatory. The healthcare policy will only become effective on the day we receive such additional information. You will receive a confirmation of receipt stating the date on which we received your additional information.

6.1.3. If you have a different healthcare policy on the day as set out in Article 6.1.1 or 6.1.2, the healthcare insurance policy will become effective on the later date you indicated.

6.1.4. If the previous insurance policy has been terminated effective 1 January of a calendar year or due to a change in the conditions, the new insurance policy will commence at the new insurer as per the termination date of the old insurance policy. In that case you must register with the new healthcare insurer within one month of termination of the previous insurance policy.

6.1.5. If the insurance contract becomes effective within 4 months of the start date of mandatory insurance, the healthcare policy will become effective on that start date.

> Example
> It is mandatory for you to insure your child within 4 months of childbirth, ensuring that your child is insured from the date it was born.

6.1.6. The Healthcare Insurance Act includes provisions relating to mandatory insurance. It is not mandatory for us to conclude a healthcare policy with or for a person subject to mandatory insurance if that person is already insured pursuant to the Healthcare Insurance Act.

6.2. Termination by operation of law

The healthcare insurance terminates by operation of law from the day following the day on which:

- the healthcare insurer is no longer permitted to offer or execute healthcare insurance policies due to a change in or suspension of its licence to operate a non-life insurance business. We will disclose any such changes at least 2 months in advance;
- the insured person dies;
- the insured person's obligation to take out insurance terminates.

You, as the policyholder, have the obligation to inform us of the death of an insured or of the end of mandatory insurance of an insured as soon as possible. If you do not notify us of the end of mandatory insurance of an insured on time and we pay the cost of healthcare to a healthcare provider, we will claim these costs from you. If we conclude that the healthcare insurance cover has terminated, we will send you a confirmation accordingly as soon as possible.

6.3. When can you change or cancel your insurance policy?

6.3.1. Change

Do you want to change your basic insurance policy to a different basic insurance policy? Then please send us the instructions latest by 31 January. Your new insurance policy will start on 1 January (with retroactive effect).

6.3.2. Annual cancellation

As the policyholder, you are entitled to terminate the healthcare insurance policy annually as per 1 January, subject to receiving your notice in writing latest by 31 December of the previous year. You will then have until 1 February to find another insurer who will insure you with retrospective effect to 1 January.

6.3.3. Intermediate termination

You, as the policyholder, are entitled to intermediate termination of the healthcare insurance policy in writing:

- of another insured if this insured has taken out a different healthcare policy. If you cancel the healthcare policy before the other healthcare policy becomes effective, the termination date will coincide with the start date of the new healthcare policy. If the cancellation notice was received later, the cancellation date will be the first day of the second calendar month after receipt of your cancellation notice;
- within six weeks after you received a notification about us as referred to in Section 78c, second subsection, or Section 92, first subsection, of the Healthcare Market Organisation Act. The cancellation date will be the first day of the second calendar month after receipt of your cancellation notice;

- in the event of changes to the premium and/or conditions as set out in Article 5.2;
- if you participate in one of our group contracts with your former employer, and you are offered to participate in the group contract of your new employer. You may then cancel the healthcare insurance at any time up to 30 days after the new employment commences. In that event both the cancellation and the registration become neffective on the start date of the employment at the new employer if that is the first day of the calendar month, and, if not, then on the first day of the calendar month following the start date of the employment.

Cancellation upon 18th birthday
You may cancel your child's insurance upon his/her 18th birthday. Your child may then conclude his/her own healthcare insurance policy.

6.3.4. Cancellation service
For cancellation of the insurance policy as set out in Articles 6.3.2 and 6.3.3, you may also make use of the cancellation service of the Dutch healthcare insurers. This means you authorise the insurer of your new healthcare policy to cancel the healthcare policy with the previous insurer.

6.3.5. When is cancellation not possible?
If we sent you a reminder for arrears in premium payments, you are not permitted to cancel your healthcare policy during that period until full payment of the premium, interest and collection fees has been received. You may cancel the healthcare policy if we suspended cover or if we confirm your cancellation within 2 weeks.

6.4. When are we entitled to cancel, dissolve or suspend the insurance contract?
We are entitled to cancel, dissolve or suspend the insurance policy in writing:
- in the event of past-due payments as set out in Article 3.6;
- in the event of fraud (see Article 2.4);
- if you intentionally have not provided any, incomplete or incorrect information or documents that have or could have worked to our disadvantage;
- if you acted with the intent of misleading us, or if we had not accepted your application for a healthcare insurance policy/policies if we had known the actual circumstances. In such cases we reserve the right to cancel the healthcare policy within 2 months of detection and with immediate effect. In such cases we are not liable for paying out any amounts, or we may reduce the amount to be paid out. We reserve the right to set off such recovery claims against other payments.

6.5. Certificate of cancellation
Upon termination of the healthcare policy, you will receive a termination confirmation with the following details:
- name, address, place of residence and citizen service number (BSN) of the insured;
- name, address and place of residence of the policyholder;
- the day on which the healthcare policy terminates;
- whether on that day an excess applied and if yes, the amount of this excess.

Upon termination of mandatory insurance, the end date is also stated in the confirmation.

6.6. Insuring non-insured persons
If the CAK concluded this healthcare policy on your behalf pursuant to Section 9d, subsection 1 of the Health Insurance Act, the following applies:
a. you may deem this healthcare policy null and void if you can demonstrate within 2 weeks to both us and the CAK that you already have healthcare insurance. This 2-week period starts on the date on which the CAK informed you that it concluded this healthcare policy on your behalf;
b. we may lawfully reverse this healthcare policy due to error if you demonstrate that you are not subject to mandatory insurance;
c. you are not permitted to cancel this healthcare policy during the first 12 months. After these 12 months, the customary termination options as stated in Article 6.3 become effective.

Article 7 Statutory excess

7.1. Amount of statutory excess
If you are age 18 or older, a statutory excess of €385 per calendar year applies. The costs of healthcare are charged to you up to this amount. If you reach age 18 in the course of a calendar year, the statutory excess applies from the first day of the calendar month following the calendar month after your 18th birthday. The amount

7.2. The types of care to which the statutory excess is applicable

The statutory excess is applicable to all types of care as included in these policy conditions, with the exception of:

- general practitioner care. The excess is applicable to medications. The excess is also applied for laboratory tests and diagnostics conducted by a different healthcare provider at the request of the general practitioner and charged to you. See Article 11, General practitioner care;
- a combined lifestyle intervention as set out in Article 12;
- nursing and care as set out in Article 13;
- obstetric care by an obstetrician, general practitioner or gynaecologist. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport are set off against the statutory excess. See Article 14.1, Obstetric care, and Article 15, Specialist medical care;
- maternity care. Please refer to Article 14.2, Maternity care;
- the Stop Smoking programme as set out in Article 23. The excess is applicable to medications;
- preferred medications as set out in the Pharmaceutical Care Regulations. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your excess. See Article 34, Medications;
- the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar as they supply the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your excess. See Article 34, Medications;
- the preferred and selected liquid nutrition products as set out in the Pharmaceutical Care Regulations. See Article 35, Dietary Preparations;
- leased medical aids. Please refer to Article 36, Medical aids and bandaging;
- post-op check-ups after a kidney or liver donation, after the period set out in Article 21, item d, Tissue and organ transplants has expired;
- transport of a donor as set out in Article 21, Tissue and organ transplants;
- any personal contributions and/or personal payments.

7.3. The relevant healthcare providers and healthcare arrangements to which the statutory excess is not applicable

We have the option of appointing healthcare providers or healthcare arrangements where you are charged no amount or a smaller amount of statutory excess. This also applies to health-promoting or preventive healthcare arrangements to be specified further. This information is available from our website.

7.4. Calculation method of amount of statutory excess

If the healthcare policy does not start or end on 1 January, we calculate the excess as follows:

$$\text{Excess} \times \frac{\text{number of days that the healthcare policy was effective}}{\text{the number of days in the relevant calendar year}}$$

This amount will be rounded off to the nearest whole euro.

> Example
> The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2019 has 365 days. The excess is: €385 x 30 divided by 365 is €31.64 and is rounded off to €32.

7.5. Calculation of statutory excess

When calculating the excess, the costs of care or another service will be allocated to the calendar year in which the care was received. If a treatment falls in 2 calendar years and the healthcare provider may charge the costs as a single amount (for example the Diagnosis and Treatment Combination), these costs will be charged to the excess of the calendar year in which the treatment started.

Article 8 Voluntary excess

8.1. Variations voluntary excess

If you are age 18 or older, you may select a healthcare policy with a voluntary excess amounting to: €0, €100, €200, €300, €400 or €500 per calendar year. The costs of healthcare are charged to you up to this amount. Depending on the selected amount of the voluntary excess, you will receive a discount on the premium base. The selected voluntary excess and any discounts are stated on the policy schedule.

8.2. The relevant types of care to which the voluntary excess is applicable

The voluntary excess is applicable to the same healthcare types as set out in Article 7.2.

8.3. Calculation method of amount of voluntary excess

8.3.1. If the healthcare policy does not start or end on 1 January, we calculate the voluntary excess as follows:

$$\text{Excess} \times \frac{\text{number of days that the healthcare policy was effective}}{\text{the number of days in the relevant calendar year}}$$

This amount will be rounded off to the nearest whole euro.

> Example
> You selected a voluntary excess of €100. The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2019 has 365 days. The voluntary excess is: €100 x 30 divided by 365 is €8.22 and is rounded off to €8. The statutory excess is €385 x 30 divided by 365 is €31.64 and is rounded off to €32. The total excess amounts to €40 (€32 statutory excess and €8 voluntary excess).

8.3.2. If the healthcare insurance policy does not become effective on 1 January and you had taken out a healthcare policy with us previously with a different voluntary excess amount, then the total voluntary excess is calculated as follows:
a. each amount of voluntary excess x the number of days that the voluntary excess is applicable
b. the sum of the amounts stated under a divided by the number of days in the relevant calendar year;
c. the result of this amount will be rounded off to the nearest whole euro.

8.4. Amendments to voluntary excess

You may change the voluntary excess annually as per 1 January. You are required to forward us such changes latest by 31 January. The change will then become effective as per 1 January (with retroactive effect).
8.5. Calculation of statutory and voluntary excess
If a voluntary excess applies, the healthcare costs will first be deducted from the statutory excess and subsequently from the voluntary excess. The provisions set out in Article 7.5 apply for the calculation of the voluntary excess amount relating to treatment spread over 2 calendar years

Article 9 Abroad

9.1. If you are living in or residing in an EU/EEA or treaty country outside the Netherlands

If you are living in or residing in an EU/EEA or treaty country outside the Netherlands, you are entitled to the following healthcare:

- healthcare in accordance with the statutory insurance package in an EU/EEA country or treaty country, if applicable to you. This right to healthcare is set out in the EU social security regulations or a social security treaty;
- healthcare provided by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider.
  We will reimburse the costs up to a maximum of the amount you would receive if you selected a non-contracted healthcare provider in the Netherlands. For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

> Please note
> In the event of emergency care provided by a non-contracted healthcare provider, you are entitled to reimbursement of the costs up to the Wmg rates applicable in the Netherlands or the reasonable market-level rates as applicable in the Netherlands. In the event of foreseeable healthcare where a contracted healthcare provider knows or expects that it cannot be delivered or not in time, we may reimburse the healthcare costs for a non-contracted healthcare provider up to a maximum of the Wmg rates applicable in the Netherlands or the reasonable marketlevel rates as applicable in the Netherlands.

> European health card (EHIC)
> On the reverse of your healthcare card, you can find the EHIC. If you travel to an EU/EEA country or Switzerland, this card entitles you to necessary medical care abroad. You can use the EHIC in Australia for emergency medical care. You may only use this EHIC if you are insured with us. If you use this EHIC abroad, while you know or could reasonably know that it is no longer valid, the cost of healthcare will be charged to you.

9.2. If you are living in or residing in a non-EU/EEA country or non-treaty country

If you are living in or residing in a non-EU/EEA country or non-treaty country, you may choose healthcare in your country of residence or temporary residence and select:

- healthcare provided by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the amount you would receive if you selected a non-contracted healthcare provider in the Netherlands. For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

> Please note
> The costs of treatment abroad may be higher than the costs of the same treatment in the Netherlands. We will reimburse the costs up to the amount you would receive if you had the treatment in the Netherlands. Therefore please take into consideration that you will likely have to pay for a (large) part of the bill yourself if you are having treatments abroad.

9.3. Approval and/or referral

You would like to be treated abroad? If you are hospitalised in a hospital or a different institution for 1 or more nights, you will require our prior approval. You also require permission for healthcare abroad as set out in the healthcare provisions (Articles 11 through 39). These healthcare provisions also set out if you need a referral or prescription.
If you do not require our approval, but you would like to know in advance if your treatment abroad would be eligible for reimbursement, you can contact us and ask us for an assessment. For more information, please check our website.
You do not require prior approval if you are unexpectedly hospitalised and the treatment cannot reasonably be postponed until you have returned to your country of residence. If you are taken in for 1 or more nights, you must call, or have someone call, our emergency response unit. Please find the emergency response telephone number on both your healthcare card and our website.

Article 10. Complaints and disputes

10.1. Do you have a complaint? Please submit your complaint to the Complaints Management department

You may rest assured that we organise everything carefully relating to your healthcare insurance policy. However, one hundred percent satisfaction is not always achievable. We are open to hearing your complaints and suggestions. Please contact our customer service. The telephone number is available from our website. Please feel free to submit your complaint in writing to 'afdeling Klachtenmanagement' (the Complaints Management department), PO Box 2705, 6401 DE HEERLEN, the Netherlands. The Complaints Management department acts on behalf of the management board.

> Tips for submitting a complaint
> - Please indicate in as much detail as possible what happened, what you are dissatisfied with, what you think is the best solution and when you can best be reached.
> - Please attach all relevant documents. Please do not send any originals with your complaint. After all, you may still need the originals.
> - If you are unable or unwilling to submit your complaint, you can have someone else do this on your behalf and designate a proxy. However, for privacy reasons, we will require your permission in writing to deal with such a proxy. We cannot process the complaint until we receive your permission.

You will receive a response from us within 30 days. If you are not satisfied with the decision or if you have not received any response within 30 days, please feel free to submit your complaint or dispute to SKGZ (Foundation Complaints and Disputes Healthcare Insurance), PO Box 291, 3700 AG Zeist, the Netherlands, www.skgz.nl. Alternatively, you may submit the dispute to the competent court of law.

10.2. Complaints about our forms

If you feel one of our forms is superfluous or complicated, please contact our customer service. The telephone number is available from our website. Alternatively, you may submit your complaint in writing to the 'afdeling Klachtenmanagement', PO Box 2705, 6401 DE HEERLEN, the Netherlands.
Alternatively, you can submit your complaint to the Dutch Healthcare Authority for the attention of the Information Line/the Notification Centre, PO Box 3017, 3502 GA Utrecht, the Netherlands, email: info@nza.nl. The website of the Dutch Healthcare Authority, www.nza.nl, sets out how to submit a complaint about forms.

II Healthcare Provisions

Medical Care

Article 11 General practitioner care

This is your cover
You are entitled to reimbursement of the cost of:

1. Medical care as offered by general practitioners including the associated laboratory tests and diagnostics.
   Healthcare provided by general practitioners also includes health advice, counselling for quitting smoking, pre-conception healthcare (pregnancy wish visit) and foot care if you have diabetes mellitus type 1 or 2.

   Quitting smoking
   Counselling for quitting smoking is defined as:
   - short treatments, such as one-off short counselling sessions for quitting smoking;
   - intensive forms of treatment aimed at behavioural change (in a group or as an individual).

   If you attend a Stop Smoking programme with your general practitioner in accordance with the Healthcare Module Stop Smoking, please refer to Article 23. Your general practitioner can provide more details.

   Pre-conception healthcare
   Pre-conception healthcare (pregnancy wish visit) is defined as:
   - advice on healthy nutrition;
   - advice on intake of folate acid;
   - advice on intake of vitamin D;
   - advice on quitting smoking, alcohol and drugs, if necessary with active counselling to realise this;
   - advice on using medication;
   - advice on treatment of existing conditions and previous pregnancy complications;
   - advice on infectious diseases and vaccinations;
   - tracking risks based on your health history and offering genetic counselling if you are not (yet) pregnant.

   Foot care for diabetes mellitus
   The aforementioned foot care for diabetes mellitus is defined as:
   - annual foot screening consisting of a review of the medical history, a risk assessment and determining the care profile;
   - from care profile 1: annual specific foot examination and advice on adequate footwear, foot care advice and advice relating to managing load and capacity;
   - from care profile 2: more frequent specific foot examination, check-ups and diagnostics, treatment of skin and nail problems, foot shape and position deviations and other risk factors.

   You are entitled to reimbursement of the cost of this foot care as part of general practitioner care or as part of multidisciplinary care as described in item 3.1. These foot treatments do not include foot care such as removing hard skin for purely cosmetic or personal care reasons and general nail care such as clipping nails. The care profiles are set out in the Healthcare Module Prevention Diabetic Foot Ulcers. Care profiles give insight into the foot care required based on a risk classification of patients with diabetes mellitus. The Healthcare Module is available from our website. Your general practitioner can tell you which care profile applies to you.

2. Specialist medical care bordering on the medical domain of the general practitioner.
   Examples of such healthcare include:
   - regular or minor surgery interventions;
   - ECG diagnostics (heart images);
   - lung function test (spirometrics);
   - diagnostics based on the Doppler test (testing the blood flow in the vascular system);
   - MRSA screening (screening for Meticillin Resistant-
   - audiometrics (hearing system testing);
   - IUD (pessary) application or removal, implantation or removal etonogestrel implantation rod. If you are age 21 and up, you are not entitled to reimbursement of a contraceptive, excepting for treatment of endometriosis or menorrhagia (if suffering from anaemia). See Article 34
   - medically necessary circumcision;
   - therapeutic injections (Cyriax).

11.1 Multidisciplinary healthcare relating to:

- diabetes mellitus type 2 (DM type 2);
- chronic obstructive pulmonary disease (COPD; this is a group of lung conditions, such as chronic bronchitis and lung emphysema);
- cardiovascular diseases (care if you are a patient with a cardiovascular condition).

11.2. Contracted multidisciplinary healthcare relating to:

- increased vascular risk management (care if you have an increased risk of cardiovascular diseases);
- asthma (if you are age 16 or older);
- target group vulnerable elderly.

Your healthcare group may only charge this care if it has an agreement with us to this end.

Multidisciplinary care (chain healthcare)
Multidisciplinary care specifically developed to organise healthcare for chronic patients in a region better in terms of quality and effectiveness. The healthcare providers work closely together within a healthcare group, ensuring that the healthcare you need is better aligned. The healthcare is based on a standard of care. A standard of care is a description agreed by the healthcare providers regarding which healthcare an insured should receive for a certain condition. This standard is the starting point to determine which healthcare the insured will receive and who provides the healthcare.

Healthcare group
The healthcare group is a partnership of healthcare providers with various disciplines, with a general practitioner in charge. Together, they provide chain healthcare. In addition to the general practitioner, healthcare is also delivered by a nurse, physician's assistant, dietician, podotherapist or pedicurist, for example.

Excess
No excess applies for this healthcare. The excess is applicable to medications. The excess is also applied for laboratory tests and diagnostics conducted by a different healthcare provider at the request of the general practitioner and charged to you. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. For general practitioner care (items 1 and 2) and multidisciplinary care (item 3.1):
   medically qualified general practitioner, healthcare group or third parties. Under the medical responsibility of a general practitioner, this care may also be administered by a medical receptionist, nurse, social worker, nurse practitioner (NP), physician assistant (PA) or practice assistant (GGZ).
   For placing or removing a diaphragm, you may also choose an obstetrician certified for this service. Your obstetrician can provide more details.
2. For foot care for diabetes mellitus:
   - A podiatrist who is registered with the Quality Register Paramedics
   - A medical pedicurist registered in ProCert's KRP (Quality Register for Pedicures)
   - A pedicurist with the certification 'Diabetic foot'
   - A pedicurist registered in the Stipezo Register Paramedische Voetzorg (RPV or Register Paramedic Footcare);
   - A pedicurist registered in the Kwaliteitsregister Medisch Voetzorgverleners (KMV or Quality Register Medical
   - Footcare Providers) of Nederlandse Maatschappij Medisch Voetzorgverleners (NMMV or Dutch Association of
   - Medical Footcare Providers).

   The podiatrist will prepare the treatment plan and will determine which part of the treatment may be performed by a medical or other pedicurist.
3. For contracted multidisciplinary care (item 3.2):
   A contracted healthcare group.

An overview of the partnerships between podotherapists and pedicurists is available from our website.
You could also ask your general practitioner about the options for multidisciplinary care.
If you select a non-contracted healthcare group for contracted multidisciplinary care as described in item 3.2, you are not entitled to reimbursement.
If you are not making use of multidisciplinary care or this care is not available in your region, you are entitled to reimbursement of the cost of healthcare provided by individual healthcare providers pursuant to the relevant healthcare provisions, including general practitioner healthcare services (items 1 and 2) and dietetics (Article 29).

Article 12 Combined lifestyle intervention

This is your cover
If you are age 18 or older, you are entitled to reimbursement of the cost of a combined lifestyle intervention (GLI). A GLI is an accredited programme concerning healthy diet, eating habitation and exercising more to develop and continue a healthy lifestyle. You are eligible for an accredited programme if you are at a medium increased weight-related health risk (GGR). The GGR is determined based on the standard of care for obesity. Please find the accredited programmes on our website. A programme is completed in 24 consecutive months. You are not entitled to reimbursement of the cost of exercise or assistance with exercise.

Excess
No excess applies for this healthcare.

This is where to go
1. A lifestyle coach registered with the Professional Association of Lifestyle Coaches Netherlands (BLCN)
2. A physiotherapist, remedial therapist, dietician or occupational therapist registered as a lifestyle coach.

Referral letter required from
General practitioner.

Article 13 Nursing and care (district nurses)

This is your cover
Your right to reimbursement of the cost of nursing and care as nurses generally provide, such without stay in an institution. The healthcare is related to the need of medical care as set out in Article 2.4 of the Healthcare Insurance Decree, or a high risk of needing such care. This healthcare includes coordination, detection, prevention, instruction and supporting the independent management and independence level of the clients, the client system and case management. You may be entitled to reimbursement of the cost of professional healthcare follow-up if you made use of an emergency call via personal alarms (for example if you fell in your home).

This healthcare also includes nursing day care intensive child care in a nursing children's day care or children's hospital. Intensive child care (IKZ) is care to children up to age 18 who have a need for care as nurses generally provide related to medical care or a high risk of such. These children also have a need of permanent supervision or 24-hour care in the vicinity.

You are entitled to reimbursement of the cost of this healthcare only if you have an indication for nursing and/or care and a treatment plan was prepared for you. The indication is prepared by a nurse, level 5, or a nursing specialist. The nurse consults with you to prepare a treatment plan in compliance with the guidelines of the occupational group Nursing & Caring in the Netherlands. The treatment plan describes the healthcare you need in terms of nature, scope and duration and the goals set.
The indication for nursing and care for insured persons under age 18 is prepared by a paediatric nurse, level 5, or a nursing specialist. The nurse consults with the parents and paediatrician to prepare a treatment plan. The treatment plan describes the healthcare you need in terms of nature, scope and duration and the goals set.

Personal Budget (pgb)
You may be entitled to reimbursement of nursing and care in the form of a personal budget (pgb). This requires our prior approval. The Nursing and Care Personal Budget Regulations set out the terms and conditions that apply to having a pgb. The Nursing and Care Personal Budget Regulations are available from our website.

Excess
No excess applies for this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A nursing specialist, nurse, health care worker level 3 and healthcare worker in individual nursing healthcare (VIG staff).

Approval
You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

Extra information
The general practitioner or medical specialist assesses if palliative terminal healthcare is appropriate. Palliative terminal healthcare is care in the last phase of life with a life expectancy of less than 3 months.

Article 14 Obstetric care and maternity care

14.1. Obstetric care

This is your cover
You are entitled to reimbursement of the cost of obstetric care, including prenatal and postnatal care, as offered by obstetricians. Obstetric care includes the use of a delivery room if the delivery takes place in a hospital or birth clinic due to medical necessity.

This care also comprises:
- Pre-conception healthcare (pregnancy wish visit)
  If you wish to get pregnant, you can make use of pre-conception healthcare. Article 11, item 1 indicates the elements included in this type of care.
- Counselling:
  if you are pregnant and you are considering pre-natal screening for birth defects, you will generally require an extensive consultation with your general practitioner, obstetrician or medical specialist first. This consultation visit is referred to as counselling. During this visit you will receive information on the content and scope of pre-natal screening. You are then well equipped to make a decision on such screening. This refers primarily to the combination test and the twenty-week ultrasound testing (SEO; Structural Echoscopic Testing).
- The combination test, the non-invasive pre-natal test (NIPT) and the invasive diagnostics if you have a medical indication. You are also entitled to reimbursement of the cost of an NIPT if a combination test shows that you have a significant risk of having a child with a chromosome anomalies. You are also entitled to reimbursement of the cost of invasive diagnostics (chorionic villus testing or amniocentesis) if a combination test or NIPT shows that you have a significant risk of having a child with a chromosome anomaly.
- Twenty-week ultrasound (anomaly scan, or SEO):
  the anomaly scan can be used to check if your baby may have a physical anomaly, such as spina bifida. This test is called the Structural Ultrasound Test (SEO in Dutch, second trimester). This test takes place around the twentieth week of pregnancy.

Prenatal diagnostics:
The combination test, NIPT and invasive diagnostics (chorionic villus testing or amniocentesis)
If your medical healthcare provider indicates an elevated risk of a child with Down syndrome, Edwards syndrome or Patau's syndrome (trisomy 21, 18 or 13), you are entitled to reimbursement of the cost of prenatal diagnostics.

If you do not have a medical referral
If you do not have a medical referral, you may decide on a combination test or NIPT at your own expense.
- If the combination test shows that you have a significant risk of having a baby with a chromosomal anomaly, you are entitled to reimbursement of the cost of an NIPT or invasive diagnostics.
- If the NIPT shows that you have a significant risk of having a baby with a chromosomal anomaly, then you are entitled to reimbursement of the cost of invasive diagnostics.

Excess
No excess applies for obstetric care. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport are set off against the statutory excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
An obstetrician or general practitioner with further training and who specialises in physiological obstetrics. Integral maternity care may be supplied by an Integral Maternity Care Organisation contracted by us.

Integral maternity care
Obstetricians, maternity care nurses and gynaecologists collaborating in an Integral Maternity Care Organisation are permitted to agree on an integral rate for maternity care with us. Integral maternity care is designed to lubricate the collaboration between the various healthcare providers, resulting in improved quality of healthcare for both mother and child. The Integral Maternity Care Organisation may only charge this care if it has an agreement with us to this end. An overview of contracted Integral Maternity Care Organisations is available from our website.
You may change healthcare providers during pregnancy, maternity and aftercare.

The combination test and the twenty-week ultrasound may only be performed by a healthcare provider with a permit pursuant to the Wet op het bevolkingsonderzoek (Population Screening Act), or a healthcare provider with a partnership agreement with a Regional Centre for Prenatal Screening. As soon as there is a medical indication, the examination may be performed without such a permit. You can select a university centre for the NIPT and a centre for pre-natal diagnostics for the invasive diagnostics.

14.2. Maternity care

This is your cover
You are entitled to reimbursement of the cost of nursing as generally offered by maternity assistants to the mother and child in connection with a delivery, during a period of no more than 10 days counting from the day of the delivery. The obstetrician or general practitioner providing the obstetric care determines the number of maternity care hours based on the Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care). You are entitled to reimbursement of the cost of at least 24 hours up to a maximum of 80 hours, divided over a maximum of 10 days. Please find this protocol on our website.

For every day of hospitalisation during which maternity care was provided in hospital for some part, we will deduct the average number of hours of maternity care (this is the number of indicated hours of maternity care divided over 10 days) per day from the number of maternity care hours as indicated. If more than one healthcare institution (for example hospital and maternity care organisation) has charged maternity care for the same day, you are also entitled to reimbursement of the cost of maternity care on this 'double day'.

Please note
Request maternity care at least 5 months prior to the expected due date via our website. Then you can be assured that your request will be processed in time.

Personal contribution
You are charged a statutory personal contribution amounting to:
- €4.40 per hour for maternity care at home or in a birth clinic;
- €17.50 per day for both mother and child if the delivery takes place in a hospital or birth clinic without medical necessity. In addition to the personal contribution, you are charged the cost difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of €125 per day for both mother and child.

Excess
No excess applies for this healthcare.

This is where to go
A certified maternity assistant or a nurse. Maternity care as part of integral maternity care may be supplied by an Integral Maternity Care Organisation contracted by us. Please find more information about integral maternity care in Article 14.1, Obstetric care.
An overview of contracted Integral Maternity Care Organisations is available from our website.

Extra information
Did you select a non-contracted maternity assistant or obstetrician? Please send a copy of the following with your invoice for maternity care:
- The indication in accordance with the Landelijk Indicatie Protocol Kraamzorg (LIP - National Referral Protocol Maternity Care);
- The certificate Maternity care assistant if the maternity care is provided by a maternity care assistant.

You can request copies of such documents from your maternity care organisation and/or the independent maternity assistant or nurse.

Which obstetric care and maternity care are included in your healthcare policy?

Delivery and maternity care at home	
Delivery at home	Yes.
Maternity care at home	Maximum of 10 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to €4.40 per hour.
Delivery and maternity care in birth clinic or hospital with medical necessity	
Delivery in birth clinic or hospital with medical necessity	Yes.
Maternity care in a birth clinic	Maximum of 10 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to €4.40 per hour.
Maternity care in hospital after childbirth with medical necessity	Yes. This is not subject to a personal contribution.
Delivery without medical necessity and maternity care in birth clinic or hospital	
Delivery in birth clinic delivery room without medical necessity	Yes. The maximum reimbursement for mother and child together amounts to €215 per day. This reimbursement is calculated as follows: • Maximum reimbursement is 2 x €125: € 250 per day • Less: personal contribution is 2 x €17.50: € 35 per day € 215 per day The difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of €215 per day is charged to you personally.
Delivery and maternity care without medical necessity for stay in a hospital	
Delivery without medical necessity in a birth clinic or hospital as part of integral maternity care by an Integral Maternity Care Organisation contracted by us	Yes. The personal contribution for mother and child together amounts to €370.73.
Maternity care in a birth clinic	Maximum of 10 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to €4.40 per hour.

Medical necessity

Your obstetrician or general practitioner providing obstetric care determines whether or not there is a medical necessity for delivery in a hospital or birth clinic.

Article 15 Specialist medical care

This is your cover

You are entitled to medical care as generally offered by a medical specialist including the associated tests, laboratory tests, medications, bandaging and medical aids. Specialist medical care also includes:

- care provided by a thrombosis unit;
- second opinion from a medical specialist.
  This is subject to a referral from the healthcare provider treating you. This may concern the relevant general practitioner, obstetrician or medical specialist, for example. The second opinion must relate to the medical care that you already discussed with your first healthcare provider. You are required to return to your original healthcare provider with the second opinion, as the first person will remain the leading provider in your treatment;
- dialysis in a dialysis centre, hospital or at home;
- chronic intermittent respiration and the required equipment;
- counselling for quitting smoking. This includes one-off short advice for quitting smoking;
- medically necessary circumcision.

Specialist medical care also comprises:

a. up to 1 October 2019, treatment of colon carcinoma with adjuvant hyperthermic intraperitoneal chemotherapy (HIPEC), insofar as you are participating in main research as outlined below;
b. up to 1 July 2019, treatment with tumour-infiltrating lymphocytes of metastasised melanoma irresectable stage IIIc and stage IV insofar as you are participating in research as outlined below;
c. up to October 2022, mammary reconstruction after breast cancer with autologous fat transplants, insofar as you are participating in main research as outlined below;
d. from 1 January 2016 to 1 December 2020, treatment of lumbosacral radicular syndrome for lumbar hernia with percutaneous transforaminal endoscopic discectomy, insofar as you are participating in research as outlined below;
e. from 1 January 2016 to 1 January 2020, occipital nerve stimulation treatment of chronic cluster headaches for which medications are ineffective, insofar as you are participating in research as outlined below;
f. from 1 April 2016 to 1 August 2021, dendritic cell vaccinations in patients with stages IIIB and IIIC melanoma after complete resection, insofar you are participating in research as outlined below;
g. from 1 October 2016 to 1 July 2021, sacral neuromodulation for therapy-resistant, functional obstipation with delayed intestinal passage, insofar as you are participating in research as outlined below;
h. from 1 January 2017 to 1 January 2023, intensified, alkylating chemotherapy with stem cell transplant for the treatment of patient of ages 18 to 65 who have BRCA1-like, stage III breast cancer, insofar as you are participating in research as outlined below;
l. from 1 October 2017 to 1 October 2022, combination treatment of cytoreductive surgery and hypertherm intraperitoneal chemotherapy in patient with both stomach cancer and synchronous peritoneum cancer or tumour-positive stomach fluid, insofar as you are participating in research as outlined below.

Research is defined as:

- main research into the effectiveness of the healthcare funded by the Dutch organisation for healthcare research and healthcare innovation (ZonMW); and/or
- supplementary national observational research into the healthcare set up and performed in collaboration with the main research if you:
  1. fulfil all criteria relating to the content of the healthcare, but you do not fulfil other criteria for participation in the research; or
  2. have not participated in the main research and the inclusion for the main research has been completed; or
  3. have participated in the main research without having received the healthcare and participation to the main research is completed for you.

The Minister of Health, Welfare and Sport has the option of classifying healthcare as conditionally admitted healthcare four times per year. The above list may not be up to date. It indicates the status insofar as known at the moment of preparing and printing these policy conditions. For the most recent list, please refer to Article 2.2 of the Healthcare Insurance Regulation.

You are not entitled to:

a. treatments with uvuloplastic surgery for snoring;
b. treatments aimed at sterilisations (for both male and female);
c. treatments aimed at reversing sterilisations (for both male and female);
d. treatment of plagiocephaly and brachycephaly without craniosynostosis with a cranial band;
e. fertility-related care if you are a woman age 43 or older, unless it concerns an in-vitro fertilisation attempt that was started before reaching age 43.

Excess

This healthcare is set off against the excess.
No excess applies for obstetric care by a gynaecologist. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport invoiced separately are set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A medical specialist. The care may also be provided by a clinical physician audiologist, geriatric medical specialist, emergency aid physician KNMG, specialist nurse or physician assistant (PA) if the indicated care falls within the area of expertise of that healthcare provider.

Integral maternity care

Obstetricians, maternity care nurses and gynaecologists collaborating in an Integral Maternity Care Organisation are permitted to agree on an integral rate for maternity care with us. This rate may only be charged by the maternity care organisation subject to a contract with us. An overview of contracted Integral Maternity Care Organisations is available from our website.

Referral letter required from

General practitioner, specialist nurse, physician assistant (PA), emergency aid physician KNMG, audiologist, company doctor, youth healthcare doctor, geriatric medical specialist, doctor for mentally disabled, dentist, obstetrician, ophthalmologist, medical specialist or dental surgeon.

Approval

Some treatments are subject to prior approval if specific conditions apply. Such treatments are included in the Limitative list of DBCs (Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland to be requested in advance. Please refer to our website to see this list. Please find more information about applying for approval in Article 1.9 of these conditions.

Which type of care is subject to prior approval?

Some treatments in the context of Ophthalmology, Otorhinolaryngology, Surgery and Dermatology are subject to our prior approval because specific conditions apply.

Ophthalmology:	refractory surgery (eye laser treatments or lens implants aimed at reducing dependency on spectacles or contact lenses), eyelid corrections.
Otorhinolaryngology (ENT):	ear treatments and treatment of nasal shape deviations.
Surgery:	gynaecomasty (breast formation in men), mammary hypertrophy (abnormal breast size), abdominal wall corrections.
Dermatology:	benign (non-malignant) tumours, pigment disorders, vascular dermatosis (wine spots).

If in doubt, we recommend contacting us to check if prior approval is required for any treatment. Your medical specialist must notify you that you need to pay the cost of healthcare personally unless prior approval was issued.

Please note

Any treatments with a plastic surgery nature are always subject to prior approval. For details, please refer to Article 20, Plastic and/or reconstructive surgery.

Extra information

1. Please find more information on home dialysis on our website.
2. The Healthcare Insurance Scheme may exclude certain forms of medical care as generally offered by specialists. The Healthcare Insurance Scheme is available from our website.

Article 16 Rehabilitation

16.1. Rehabilitation

This is your cover

Your right to reimbursement of the cost of medical care as referred to in Article 11 (General practitioner care) and Article 15 (Specialist medical care) during rehabilitation includes: examination, advice and treatment of a combined medical-specialist, paramedical, scientific-behavioural and technical rehabilitation nature, exclusively if and insofar as:

- this care is indicated as the most efficient for you to prevent, reduce or overcome a disability resulting from impairments or restrictions in the ability to move or a disability that is the result of a disorder of the central nervous system leading to limitations in communication, cognition or behaviour, and;
- this care enables you to achieve or maintain a degree of independence which, given your restrictions, is reasonably possible.

The rehabilitation as set out above also includes:

- the quick scan as part of early interventions for long-term a-specific complaints of the position and locomotor system. A-specific complaints refer to complaints for which no clear cause can be found;
- cancer rehabilitation. This healthcare is aimed at functional, physical, psychological and social problems relating to cancer, including aftercare and rehabilitation that is part of the oncology healthcare. This concerns advice and counselling where necessary relating to managing the disease, recovery, improving and maintaining the health condition. Cancer rehabilitation must be aimed at all phases you may be in (diagnosis - treatment - aftercare).

Excess

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A multidisciplinary team of experts attached to a rehabilitation institution or hospital under the guidance of a medical specialist. The quick scan as set out above must be performed with a rehabilitation doctor in charge.

Referral letter required from

General practitioner, company doctor or medical specialist.

Approval

You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

16.2. Geriatric rehabilitation

This is your cover

Your right to reimbursement of the cost of geriatric rehabilitation includes integral and multidisciplinary rehabilitation healthcare such as geriatric medicine specialists generally offer in the context of vulnerability, complex multi-morbidity (simultaneous presence of 2 or more conditions) and reduced learning and training ability, aimed at reducing the functional limitations to such extent that it enables returning to the home situation. You are entitled to reimbursement of the cost of geriatric rehabilitation for a maximum of 6 months. In special cases, we may allow for a longer rehabilitation period.

You are only entitled to reimbursement of the cost of this healthcare if:

1. the healthcare is consecutive within a week to hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree (see Article 37, Stay), where the hospitalisation was not preceded by a stay as set out in Section 3.1.1 of the Long-Term Healthcare Act;
2. you have an acute condition that caused acute mobility disorders or reduced independence, and you received prior specialist medical care for the same condition. The geriatric assessment is performed by a geriatrician, clinical geriatrician or geriatic internist at the first aid department or during an emergency visit at the geriatric polyclinic. The geriatric rehabilitation must be consecutive within a week to the geriatric assessment, also if you were not hospitalised;
3. the healthcare is initially paired with hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree.

Geriatric rehabilitation
Geriatric rehabilitation is aimed at vulnerable elderly people undergoing specialist medical treatment. For example due to a stroke, bone fracture or a replacement joint. Such elderly clients need a multidisciplinary rehabilitation programme adjusted to their individual rehabilitation possibilities and training pace, taking any other conditions into consideration (complex multi-morbidity). The aim is to help them return to their home situation and continued participation in society.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A multidisciplinary team of experts relating to geriatric rehabilitation with a geriatric medical specialist in charge.
A list of our contracted healthcare providers is available from our website.

If you selected a healthcare provider we have not contracted for the relevant care, Then please take into consideration that you will likely have to pay a part of the bill yourself. For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

Article 17 Genetic testing

This is your cover
Your right to medical care as set out in Article 15 (Specialist medical care) in the context of genetic testing includes: research into and testing of genetic disorders by means of family tree research, chromosome testing, biochemical diagnostics, ultrasound testing and DNA testing, genetic counselling and the psychosocial counselling associated with this form of care. If required for the advice to you, the research will also include research with regard to persons other than the insured. In that case those persons may also receive advice.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A centre for genetic counselling. This is an institution admitted as such and holds a licence for the application of clinical genetic research and genetic counselling.

Referral letter required from
General practitioner or medical specialist.

Article 18 In-vitro fertilisation (IVF) and other fertility-enhancing treatments

18.1 In-vitrofertilisatie (IVF)

This is your cover
Your right to reimbursement of the cost of medical care as set out in Article 15 (Specialist medical care) in the context of in-vitro fertilisation (IVF) includes the first, second and third IVF attempts for each intended pregnancy as a maximum, subject to the condition that you are age 42 or younger. If you started with a first, second or third IVF attempt, you may complete this attempt after your 43rd birthday with cover of your healthcare policy. If you are under age 38, you are only entitled to reimbursement of the cost of the first and second IVF attempts if 1 embryo is placed each time.
A realised pregnancy is defined as an ongoing pregnancy of at least 10 weeks from the date of the follicular puncture. Fertilisation of the egg cell takes place immediately consecutive to the puncture. For cryos (cryo-preserved embryos), a term of at least 9 weeks and 3 days after the implantation date applies to define an ongoing pregnancy.

An IVF attempt, being healthcare in accordance with the in-vitro fertilisation method, comprises:
a. the maturation of egg cells in the woman's body by means of hormonal treatment;
b. acquiring mature egg cells (follicular puncture);
c. the fertilisation of egg cells and cultivation of embryos in the laboratory;
d. the implantation (once or several times) in the womb of one or two embryos in order to cause pregnancy.

An IVF attempt does not count until successful follicular puncture has been performed in phase b (acquiring mature egg cells). Only attempts completed or broken off beyond this point will count as attempts. Placing the embryos obtained from a previous treatment phase (whether or not cryopreserved) is part of the IVF attempt with which the embryos were acquired. If any embryos remain after an ongoing pregnancy was achieved, you are entitled to reimbursement of the cost of having the embryos placed pursuant to Article 16.2, Other fertility-enhancing treatments.

When are you entitled to reimbursement of the cost of another 3 IVF attempts?
After an ongoing (realised) pregnancy or (successful) childbirth, either with or without IVF, another right to reimbursement of the cost of 3 attempts for a new pregnancy wish arises in the event of undesired infertility. Also after having a new partner, another right to reimbursement of the cost of an IVF treatment process of 3 attempts arises in the event of double infertility.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A gynaecologist in an institution licensed to this end.

Referral letter required from
Gynaecologist or urologist.

Extra information
If an IVF treatment, including an ICSI treatment (intracytoplasmic sperm injection), is based on egg cell donation, the above IVF conditions also apply. You are not entitled to reimbursement of the cost of the egg cell donation.

IVF treatment abroad
Your eligibility for reimbursement of the cost of IVF treatment depends on your personal situation, for example your age and how long you have attempted to become pregnant. If you want to have IVF treatment abroad, please contact us prior to your decision. Please find our telephone number on our website.

18.2. Other fertility-enhancing treatments

This is your cover
With regard to other fertility treatments, your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes: gynaecological or urological treatments and fertility-enhancing surgery. This healthcare also includes artificial insemination and intra-uterine insemination. If you are a woman age 43 and up, then you are not entitled to reimbursement of the cost of fertility-enhancing treatments.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A gynaecologist or urologist.

Referral letter required from
General practitioner or medical specialist.

Article 19 Audiological care

This is your cover
With regard to audiological care, your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes care in connection with:
- hearing tests;
- advice about the hearing aid to be purchased;
- information about the use of the equipment;
- psychosocial care if required in connection with problems with impaired hearing;
- assistance in making a diagnosis in cases of speech impediments and language or language development disorders in children.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A multidisciplinary team of experts attached to an audiology centre under the responsibility of a medical specialist. The audiological centre must be duly accredited under the Wet toelating zorginstellingen (Care Institutions Accreditation Act).

Referral letter required from
General practitioner, audiologist, company doctor, medical specialist, youth healthcare doctor, geriatric medical specialist or doctor for mentally disabled.

Article 20 Plastische en/of reconstructieve chirurgie

This is your cover
Your right to medical care as referred to in Article 15 (Specialist medical care) includes treatment of a plastic surgery nature only if this serves to:
1. correct abnormalities in appearance accompanied by demonstrable physical functional disorders;
2. correct disfigurement caused by a disease, an accident or a medical procedure;
3. correct paralysed or weakened upper eyelids if resulting in serious limitation of the visual field, or if it is a result of a congenital deformity or a chronic disorder present at birth. Serious limitation of visual field due to paralysed or weakened upper eyelids is defined as:
   - the weakening/paralysis of the upper eyelid causes the vertical eyelid split to decrease to 7 mm or less. This means a situation where the lower edge of the upper eyelid or the overhanging skin fold hangs above the centre of the pupil by 1 mm or more. In other words, if the distance between the (lower edge of the) overhang and the centre of the pupil is 1 mm or less. The measurement is made near the centre of the pupil while you look straight ahead without straining (relaxed and measured in primary position). It must be plausible that correction of the upper eyelid will resolve the decreased visual field;
   - this must concern a visual impairment that forms an impediment in daily routines. Subjective complaints only, such as tired eyes, pressure on eyeballs, headaches, looking tired etc, are not sufficient reason or indication for limited visual field;
4. correction of congenital deformities in connection with lip, jaw and palate clefts, deformities of the facial bones, benign proliferations of blood vessels, lymphatic vessels or connective tissue, birthmarks and deformities of the urinary tract and sexual organs;
5. correction of primary sexual characteristics where transsexuality has been established;
6. surgical insertion and replacement of a breast prosthesis other than after a full or partial mastectomy;
7. surgical insertion and surgical replacement of a breast prosthesis in the event of agenesis/aplasia of the breast (lack of breast formation) in women and in male-female transgenders, subject to the following criteria:
   - absence of an inframammary fold (fold under the breast) and;
   - gland tissue of less than 1 cm, shown by an ultrasound.

What is the definition of plastic surgery treatments?
Plastic surgery treatments are defined as: intervention in the way you look by changing a shape or aspect. Such interventions are not limited to plastic surgery specialists.

When are you entitled to reimbursement of the cost of plastic surgery treatments?
Please find more details on eligibility for this type of healthcare and the criteria in the 'Reference guide assessment plastic surgery treatments'. This reference guide was prepared by the Vereniging van artsen, tandartsen en apothekers werkzaam bij (zorg)verzekeraars (VAGZ - Association of doctors, dentists and pharmacists working with healthcare insurers), Zorgverzekeraars Nederland (ZN, Healthcare Insurers Netherlands) and the Healthcare Institute Netherlands. This reference guide is available on our website.

You are not entitled to reimbursement of the cost of:
a. treatment of paralysed or weakened upper eyelids other than listed in item 3;
b. abdominal liposuction;
c. surgical insertion and/or removal of a breast prosthesis without medical necessity or for cosmetic reasons.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A medical specialist.

Referral letter required from
General practitioner, company doctor, medical specialist or dental surgeon.

Approval
You require our prior approval. The application must be accompanied by an explanation from your treating medical specialist. Please find more information about applying for approval in Article 1.9 of these conditions.

Article 21 Tissue and organ transplants

This is your cover
Your right to medical care as referred to in Article 15 (Specialist medical care) includes tissue and organ transplants, exclusively if the transplant procedure is performed in an EU or EEA member state. If the transplant procedure is performed in a different country, you are only entitled to such healthcare if the donor is your spouse, registered partner or relative in the first, second or third degree and the relevant person resides in that country.
The care mentioned in this Article also includes reimbursement of the costs of:
a. specialist medical care in connection with the selection of the donor;
b. specialist medical care in connection with the surgical removal of the transplant material from the selected donor;
c. the examination, preservation, removal and transport of the post-mortem transplant material in connection with the intended transplant;
d. the care of the donor arranged in these policy conditions for a maximum period of thirteen weeks, or in the case of a liver transplant for a maximum period of six months, after the date of discharge from the institution in which the donor was hospitalised for selection or removal of the transplant material insofar as this care is associated with this hospitalisation;
e. the transport of the donor in the lowest class of a means of public transportation within the Netherlands or, if due to medical necessity, transport by car within the Netherlands, in connection with the selection, hospitalisation and discharge from the hospital together with the care as referred to under d;
f. the transport to and from the Netherlands of a donor residing abroad, in connection with a transplant of a kidney, a liver or bone marrow with regard to an insured person in the Netherlands plus other costs involved in the transplant which are related to the fact that the donor resides abroad. The costs of staying in the Netherlands and any loss of income are not covered.
If the donor concluded a healthcare policy, the cost of transportation referred to under e and f will be charged to the donor's healthcare insurer.

Excess
This healthcare is set off against the excess. The excess does not apply for:
- post-op check-ups of a kidney or liver donor after the period set out under d has expired;
- transport of a donor such as set out under e and f.
For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A medical specialist.

Article 22 Sensory disability care

This is your cover
You are entitled to reimbursement of the cost of sensory disability care. This type of healthcare is defined as multidisciplinary healthcare relating to a visual impairment, auditive impairment or communicative impairment due to a language development disorder, or a combination of the above impairments and disorders. This healthcare is aimed at learning how to manage, reverse or compensate for the disability, with the purpose of optimising independence in daily life.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
An institution specialised in treating people with a sensory disability, with a multidisciplinary treatment team. Healthcare relating to a visual impairment: the ophthalmologist or healthcare psychologist has final responsibility for the healthcare delivered and the treatment plan. The clinical physician or other disciplines may also bear this responsibility. The activities of the clinical physician or other disciplines are limited in that case to the healthcare as set out in Section 2.5a of the Healthcare Insurance Decree, and the requirements and conditions imposed on sensory disability healthcare.

Healthcare relating to an auditive impairment or communicative impairment due to a language development disorder: the healthcare psychologist has final responsibility for the healthcare delivered. The orthopedagogist or other disciplines may also bear this responsibility. The activities of the orthopedagogist or other disciplines are limited in that case to the healthcare as set out in Section 2.5a of the Healthcare Insurance Decree, and the requirements and conditions imposed on sensory disability healthcare.

Referral letter required from
Medical specialist or general practitioner. Referral to healthcare relating to an auditive or communicative impairment may also be performed by a clinical physician-audiologist in an audiology centre.

Article 23 Stop Smoking programme

This is your cover
You are entitled to reimbursement of the cost of healthcare in accordance with the Stop Smoking programme. This programme comprises healthcare focusing on behavioural change. You are also entitled to reimbursement of the cost of medications if prescribed as part of the programme, to support behavioural change. You may attend the programme in a group or as an individual. The objective of the programme is for you to quit smoking. You may attend a Stop Smoking programme maximum once per calendar year.

Excess
No excess applies to the Stop Smoking programme. The excess does apply to the medications. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
Healthcare providers who work in compliance with the Healthcare Module Stop Smoking.
The medications may only be supplied by a pharmacist or dispensing general practitioner.

Mental Healthcare (GGZ)

Article 24 General basic mental healthcare (GB GGZ) for insured persons age 18 and older

This is your cover
If you are age 18 or older, you are entitled to generalist basic GGZ (mental healthcare) as generally offered by clinical psychologists. This healthcare includes diagnostics and specialist treatment of light to moderate, non-complex psychological conditions/disorders or stable chronic issues. Together with the leading healthcare professional, you prepare a treatment plan, agreeing on the healthcare you require and the expected term of treatment. The leading healthcare professional then determines the healthcare you are entitled to.

Generalist basic GGZ
The generalist basic GGZ is aimed at people with a light to moderate, non-complex psychological problem or disorder, or people with chronic, stable but low-risk problems. Generalist basic GGZ is always provided on an ambulatory basis. This means you frequently visit your healthcare provider for your treatment. Alternatively, the healthcare provider may treat you at home or in combination with a digital form of treatment.

The treatment (intervention) must comply with the state of science and real statistics and experience. Please find information on the treatments that are in compliance with these requirements in the GGZ Therapies Overview on our website. This overview states which therapies do or do not comply and in which situations they may be applied. Alternatively, contact your healthcare provider for more information.

You are not entitled to:
- treatment of adjustment disorders;
- assistance in work-related or relationship problems;
- psychosocial assistance;
- treatment for learning disorders;
- self-help;
- leading towards healthcare;
- prevention and service provision;
- psychological assistance relating to physical conditions;
- intelligence tests.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A healthcare provider with an approved GGZ quality classification and a registration with the GGZ Quality Certificate website.

Quality certificate GGZ
The quality certificate contributes to ensuring that the right aid is delivered by the right healthcare professionals at the right place. All healthcare providers of generalist basic GGZ and specialist GGZ have the obligation of having their own GGZ quality certificate prepared and having it registered with the GGZ Quality Certificate website. Under public data at www.zorginzicht.nl you can find which healthcare providers have an approved GGZ quality certificate and where the quality certificate can be viewed. The healthcare provider's quality certificate sets out who is responsible for the coordination of healthcare. This is the leading healthcare professional. The quality certificate can help you select your healthcare provider.

Leading healthcare professional
The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. The leading healthcare professional determines the team for treatment with these healthcare providers. Also, the leading healthcare professional ensures that you have a voice in your treatment options.

1. Leading healthcare professionals GB GGZ independent practice may include: clinical psychologist/neuropsychologist, psychotherapist, healthcare psychologists.
2. Leading healthcare professional GB GGZ in an institution may include: clinical psychologist/neuropsychologist, psychotherapist and healthcare psychologists, geriatric medical specialist, addiction doctor with KNMG profile registration, clinical geriatric medical specialist and nursing specialist. Some of the healthcare may be provided by a healthcare provider included in the DBC occupation table GGZ of the Dutch Healthcare Authorities under the final responsibility of the leading healthcare professional.
3. Leading healthcare professional GB GGZ for a treatment started pursuant to the Youth Act may include: paediatric or youth psychologist NIP and ortho-paedagogist generalist NVO. They may only perform the role of leading healthcare professional if the first treatment was performed after your 18th birthday.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, geriatric medical specialist, doctor mental disabilities or street doctor. A street doctor is a medical doctor registered with an association of street doctors, for example the Dutch Straatdokters Groep (Street Doctors Group), and only in the municipality/municipalities where he/she works as a doctor. The street doctor may only issue referrals if the client does not have a general practitioner.
Did you receive GGZ on the basis of the Youth Act and do you not have a referral letter from a referrer mentioned above? Then you will need a new referral letter.

Article 25 Specialist mental healthcare (SGGZ) for insured persons age 18 and over

This is your cover
If you are age 18 or older, you are entitled to reimbursement of the cost of medical care as generally offered by psychiatrists and clinical psychologists, including the associated medications, medical aids and bandaging. This healthcare includes diagnostics and specialist treatment of complex or very complex psychological conditions. Counselling activities may be part of the medical care if these are an integral part of your treatment. Such activities must in that case ensue from the treatment plan and be necessary to achieve the treatment objective. Also, the activities must be performed under direct management of the leading healthcare professional.
Your leading healthcare professional receives feedback on such activities. For such activities, expertise at the level of the leading healthcare professional is necessary.

Specialist mental health care
Specialist mental healthcare is about diagnostics and specialist treatment of complex and very complex psychological conditions. Specialist mental health care may be provided on an ambulatory basis for most psychological conditions. This means you frequently visit your healthcare provider for your treatment. Alternatively, the healthcare provider may treat you at home or in combination with a digital form of treatment. In some situations, hospitalisation in a GGZ institution is a medical necessity.

The treatment (intervention) must comply with the state of science and real statistics and experience. Please find information on the treatments that are in compliance with this in the GGZ Therapies Overview on our website. This overview states which therapies do or do not comply and in which situations they may be applied. Alternatively, contact your healthcare provider for more information.

U heeft geen recht op vergoeding van de kosten van:
- treatment of adjustment disorders;
- assistance in work-related or relationship problems;
- psychosocial assistance;
- treatment for learning disorders;
- self-help;
- leading towards healthcare;
- prevention and service provision;
- psychological assistance relating to physical conditions.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A healthcare provider with a certified GGZ quality classification and a registration with the GGZ Quality Certificate website.

Quality certificate GGZ
The quality certificate contributes to ensuring that the right aid is delivered by the right healthcare professionals at the right place. All healthcare providers of generalist basic GGZ and specialist GGZ have the obligation of having their own GGZ quality certificate prepared and having it registered with the GGZ Quality Certificate website. Under public data at www.zorginzicht.nl you can find which healthcare providers have an approved GGZ quality certificate and where the quality certificate can be viewed. The healthcare provider's quality certificate sets out who is responsible for the coordination of healthcare. This is the leading healthcare professional. The quality certificate can help you select your healthcare provider.

Leading healthcare professional
The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. The leading healthcare professional determines the team for treatment with these healthcare providers. Also, the leading healthcare professional ensures that you have a voice in your treatment options.

1. Leading treatment provider SGGZ (specialist mental healthcare) self-employed can be: psychiatrist, clinical psychologist, clinical neuropsychologist or psychotherapist.
2. Leading treatment professional SGGZ in an institution may include: psychiatrist, clinical psychologist, clinical neuropsychologist, psychotherapist, healthcare psychologist, geriatric specialist, addiction doctor with KNMG profile registration, clinical geriatrician or specialist nurse. Some of the healthcare may be provided by a healthcare provider included in the DBC occupation table GGZ of the Dutch Healthcare Authorities under the final responsibility of the leading healthcare professional.
3. Leading treatment provider SGGZ relating to treatment started pursuant to the Youth Act may include: paediatric or youth psychologist NIP and ortho-paedagogist generalist NVO. They may only perform the role of leading healthcare professional if the first treatment was performed after your 18th birthday.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, geriatric medical specialist, doctor mental disabilities or street doctor. A street doctor is a medical doctor registered with an association of street doctors, for example the Dutch Straatdokters Groep (Street Doctors Group), and only in the municipality/municipalities where he/she works as a doctor. The street doctor may only issue referrals if the client does not have a general practitioner.

Did you receive GGZ on the basis of the Youth Act and do you not have a referral letter from a referrer mentioned above? Then you will need a new referral letter.

Approval
You need our prior approval for specialist GGZ with stay (see Article 36, Stay). If the permitted term is about to expire, you need to personally submit a new application. You can complete the approval form for specialist GGZ together with your healthcare provider. This form is available from our website. Please submit the application at least 2 months before the expiration date. Then you can be assured that your request will be processed in time. The address to send the application to is included in the first section of these conditions. Please find more information about applying for approval in Article 1.9 of these conditions.

Paramedical Care

Article 26 Physiotherapy and Cesar/Mensendieck remedial therapy

This is your cover
You are entitled to healthcare as generally offered by physiotherapists and remedial therapists.

Up to age 18
- From the first treatment onwards, you are entitled to treatment of conditions requiring long-term or chronic treatment. This is set out in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). Please take into consideration that the duration of treatment of certain conditions is limited to a certain term.
- If you have a condition that is not specified in the List of conditions for physiotherapy and remedial therapy, you are entitled to a maximum of 9 sessions per condition per calendar year. If you still have problems with the relevant condition after these 9 sessions, you are entitled to another series of maximum 9 sessions for such a condition. In total, you are entitled to a maximum of 18 sessions per condition per calendar year.

Over age 18
Pelvic physiotherapy for urine incontinence
You have a one-off eligibility to the first 9 treatments for pelvic physiotherapy in the context of urine incontinence;

Remedial therapy for peripheral arterial vascular condition
You are entitled to a maximum of 37 remedial therapy sessions supervised by a physiotherapist or remedial therapist (walking training) for peripheral arterial vascular conditions in stage 2 Fontaine (claudication) over a maximum period of 12 months.

Remedial therapy for arthrosis in hip and knee joints
You are entitled to a maximum of 12 remedial therapy sessions supervised by a physiotherapist or remedial therapist for arthrosis of the hip or knee joint over a maximum period of 12 months.

Remedial therapy for COPD
You are entitled to remedial therapy sessions supervised by a physiotherapist or remedial therapist for COPD (Chronic Obstructive Pulmonary Disease) GOLD class II and up. The number of treatments depends on the severity of the complaints and the risk of lung attacks in accordance with the GOLD groups A, B, C or D.

Group	A	B	C	D
The first 12 months The maximum number of sessions in the 12-month period after start of treatment is:	5	27	70	70
After the first 12 months The maximum number of sessions in each 12-month period after the first year is:	0	3	52	52

Treatment of chronic conditions
From the 21st treatment onwards, you are entitled to treatment of conditions requiring long-term or chronic treatment. This is set out in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). Please take into consideration that the duration of treatment of certain conditions is limited to a certain term.

Chronic List
The list of conditions for physiotherapy and remedial therapy is also referred to as the 'Chronic List'. This name is not fully appropriate, as not all chronic conditions are listed. Listed conditions include certain conditions of the nervous system or the locomotor system, certain vascular and lung-related conditions, lymph oedema, soft tissue tumours and scar tissue on the skin. In some cases it also includes treatment of a condition after hospitalisation to accelerate recovery. Are you uncertain if your condition is listed? Please contact us in advance.
Please find our telephone number on our website.
Please find the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree) on our website. Alternatively, contact us by telephone to request a copy of the list. Please find our telephone number on our website.

You are not entitled to:
- occupational curative care. This concerns healthcare aimed at healing and treating acute and chronic physical occupational conditions;
- reintegration processes. Reintegration is the system of measures designed to ensure the occupationally disabled employee's return to the labour process;
- treatments and treatment programmes with the aim of improving physical condition, such as medical training therapy, physio fitness, movement exercises for seniors, movement exercises for overweight persons and cardio training.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
1. A physiotherapist, paediatric physiotherapist, pelvic physiotherapist, psychosomatic physiotherapist, geriatric physiotherapist and a manual therapist
2. A Cesar/Mensendieck remedial therapist or paediatric remedial therapist
3. Oedema therapy may only be performed by an oedema therapist or oedema physiotherapist, or skin therapist.

ParkinsonNet
Do you have Parkinson's syndrome and do you need physiotherapy or remedial therapy? Then you can see physiotherapists or remedial therapists that are members of the national network ParkinsonNet. For more information, please check our website.

ClaudicatioNet
Do you need remedial therapy (walking training) due to peripheral arterial vascular condition (claudication)? Then you can see physiotherapists or remedial therapists that are members of the national network ClaudicatioNet. For more information, please check our website.

Approval
You only require our prior approval if you are treated for a condition specified in the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree). You will require a statement from your general practitioner, company doctor or medical specialist demonstrating that you need treatment for a condition specified in this List. Please find more information about applying for approval in Article 1.9 of these conditions.

Article 27 Speech therapy

This is your cover
You are entitled to reimbursement of the cost of healthcare as generally offered by speech therapists if this care serves a medical purpose and recovery or improvement of the speech function or the power of speech can be expected from the treatment.
You are not entitled to reimbursement of the cost of speech therapy treatments in the context of:
- dyslexia;
- impaired language development in connection with a dialect or a different mother tongue;
- speaking in public;
- the art of declamation.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A speech therapist.
Speech therapy treatments that deviate from regular treatments may only be provided by a speech therapist registered in one of the following sub-registers of the Dutch Association for Speech Therapy and Phoniatrics (NVLF):
- Aphasia;
- Hanen programmes;
- Integral healthcare for stuttering;
- Preverbal speech therapy (eating and drinking);
- Stuttering.

Stutter therapy may also be given by a stutter therapist registered with the Nederlandse Vereniging voor Stottertherapie (NVST - Dutch Association for Stutter Therapy).

ParkinsonNet
Do you suffer from Parkinson and you require speech therapy? Then you can see speech therapists that are members of the national network ParkinsonNet. For more information, please check our website.

Article 28 Occupational therapy

This is your cover
You are entitled to reimbursement of the cost of healthcare as generally offered by an occupational therapist on the condition that this care aims to encourage or restore your self-care and the ability to cope, up to a maximum of 10 treatment hours in each calendar year.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
An occupational therapist.

ParkinsonNet
Do you suffer from Parkinson and you require speech therapy? Then you can see speech therapists that are members of the national network ParkinsonNet. For more information, please check our website.

Article 29 Dietetics

This is your cover

Your right to dietetics includes healthcare as generally offered by dieticians, if this healthcare has a medical purpose, and up to a maximum of 3 treatment hours per calendar year.

Dietetics is defined as education with a medical purpose and treating patients with diet-related therapy, focusing on eliminating, reducing or compensating for diseases or complaints that are related to or can be influenced with nutrition.

Dietetics as part of multidisciplinary care (chain healthcare)

If you have diabetes mellitus type 2, COPD (chronic obstructive pulmonary disease), increased vascular risk or asthma, and you are receiving multidisciplinary healthcare as set out in Article 11, then dietetics for these or related conditions are provided via this multidisciplinary healthcare.

Excess

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A dietician.

Oral Care

Article 30 Dental care for insured persons under the age of 18

This is your cover
If you are under age 18, you are entitled to healthcare as generally offered by a dentist. The care includes the following provisions/treatments:
1. check-ups (periodical preventive dental examination): once annually. If necessary, you are entitled to such check-ups more than once per year;
2. incidental visit;
3. removing plaque;
4. fluoride treatment from the date the first element of the adult teeth has broken through: twice annually. If necessary, you are entitled to such check-ups more than twice per year;
5. sealing (sealing pits and grooves in teeth and molars);
6. gum treatment (periodontal treatment);
7. anaesthetics;
8. root canal treatment (endodontic treatment);
9. fillings (restoration of teeth and molars with plastic materials);
10. treatment after maxillary complaints (gnathological treatment);
11. full dental prosthesis for upper and/or lower jaw, plate prosthesis or frame prosthesis (removable prosthetic devices);
12. specialist dental surgery with the exception of the insertion of dental implants;
13. X-ray tests. You are not entitled to X-ray tests for orthodontics.

If you are under age 23, then you are entitled to reimbursement of the cost of crowns, bridges and implants if it concerns replacement of one or more permanent incisor or canine teeth that have not grown or are missing due to an accident. The necessity of this healthcare must be determined before reaching age 18.

Excess
If you are age 18 and up, then this healthcare service will be set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental surgeon, dental prosthodontist or dental hygienist. The dentist or dental hygienist may work in an institution for paediatric dental care.

Approval
You need our prior approval for crowns, bridges, implants and jaw section images. Please find more information about applying for approval in Article 1.9 of these conditions.

Article 31 Specific dental care

Specialist dentistry is dental care for people with a specific condition. Such dental care takes more time and more expertise. You are only entitled to special dental care if you can retain or obtain a dental function equivalent to the dental function you would have had if you had not incurred the relevant condition.

31.1. Dental and orthodontic care in special cases

This is your cover
You are entitled to healthcare as generally offered by dentists and orthodontists which is necessary:
1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system;
2. if you have a non-dental physical or mental condition;
3. if you must undergo a medical treatment and this treatment would have inadequate results without such specialdental care. This generally concerns eliminating inflammation in the mouth. Examples of eliminating inflammation in the mouth are treatment of the gums, extracting teeth or molars, or administering antibiotics.

You are only entitled to orthodontic care if you have a very severe developmental or growth impairment in your mouth or teeth, where diagnostics or treatment by disciplines other than dental in team context is required.

Please note
Having a few adult teeth or molars missing due to a hereditary disorder is a frequent occurrence. You are entitled to special dental care if you have at least 6 teeth and molars missing (this does not include wisdom teeth).

Personal contribution
You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if it is not a matter of special cases requiring dental care.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
1. Dental healthcare in specific cases:
   dentists, certified oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon.
2. Orthodontic care in specific cases:
   A certified oral hygienist working in a centre for specialist dental care, dental surgeon, orthodontist in collaboration with a dental surgeon or a dentist registered in the Quality Register Orthodontic Association (OK register) in collaboration with a dental surgeon. Patients with a cleft lip or cleft palate may only be treated by an orthodontist in collaboration with a dental surgeon.

The healthcare may be provided in a:
1. dental care practice;
2. hospital;
3. centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthesia? Then the healthcare may only be provided in a hospital or centre for specific dental care.
A centre for specific dental care is:
1. an institution for specific dental care accredited by the Dutch Healthcare Authorities;
2. a centre that complies with the following requirements:
   - a positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - the centre works with an anaesthesiologist who is an NVA member;
   - there is a contract document with an ambulance service or hospital for transport to a hospital if required;
   - there is a contract document with a hospital near the centre for taking in patients if required;
   - the centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
   - when treating children, the dentist must be an accredited dentist-paedo-dontologist.
   Please refer to our website to see a list of such centres.

Referral letter required from
Dentist, orthodontist or dental surgeon.

Approval
You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

31.2 Dental implants

This is your cover
You are entitled to reimbursement of the cost of having a dental implant placed in the context of specific dental care:
1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/ mouth system;
2. if you have a deformation in the dental/maxillary/oral system with later onset in the form of a very severely lapsed toothless jaw and the implants serve to affix a removable prosthesis.

Implants in a very severely lapsed toothless jaw
If you have had a full dental prosthesis (dentures) for a long time, your jaw may lapse so severely that your dental prosthesis hardly has any grip. In such a case, implants can be a solution. This generally concerns 2 implants in the lower jaw with 2 buttons or a rod screwed in that serve to click on the dentures. The dentures remain removable. For prosthetic devices for insured persons of 18 and over, please refer to Article 33.

Personal contribution

You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if it is not a matter of special cases requiring dental care.

Excess

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

Dentists, certified oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon. In the event of implants in a very severely lapsed toothless jaw, this healthcare may also be provided by a dental implantologist.

The healthcare may be provided in a:
1. dental care practice;
2. hospital;
3. centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthetics? Then the healthcare may only be provided in a hospital or centre for specific dental care.
A centre for specific dental care is:
1. an institution for specific dental care accredited by the Dutch Healthcare Authorities;
2. a centre that complies with the following requirements:
   - a positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - the centre works with an anaesthesiologist who is an NVA member;
   - there is a contract document with an ambulance service or hospital for transport to a hospital if required;
   - there is a contract document with a hospital near the centre for taking in patients if required;
   - the centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
   - when treating children, the dentist must be an accredited dentist-paedo-dontologist.

Please refer to our website to see a list of such centres.

Referral letter required from

Dentist, orthodontist or dental surgeon.

Approval

You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

Article 32 Dental surgery for insured persons age 18 and older

This is your cover
If you are age 18 or older, you are entitled to reimbursement of the cost of dental surgery and associated X-rays as generally offered by dentists. You are not entitled to reimbursement of the cost of surgery treatment of gums (periodontal surgery), applying implants and non-complex extractions. Non-complex extractions concern teeth or molars your dentist could also extract.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dental surgeon.

Referral letter required from
General practitioner, company doctor, dentist, obstetrician, medical specialist or dental surgeon.

Approval
You need our prior approval for jaw osteotomy (an operation where one or both jaws are corrected). Please find more information about applying for approval in Article 1.9 of these conditions.

Article 33 Prosthetic devices for insured persons of age 18 and over

This is your cover
If you are age 18 or older, you are entitled to reimbursement of the cost of a removable full dental prosthesis for the upper and/or lower jaw, whether or not placed on implants. A removable full dental prosthesis to be placed on dental implants also includes applying the fixed part of the supra structure (the meso structure). You are also entitled to reimbursement of the cost of filling up (rebasing) and repairing such dental prosthesis.

Personal contribution
You are charged a statutory personal contribution amounting to:
- 10% of the cost for an implant-supported prosthesis in the lower jaw;
- 8% of the cost for an implant-supported prosthesis in the upper jaw;
- 25% of the cost for a regular dental prosthesis;
- 10% of the cost for repairing and rebasing your dental prosthesis.

Your personal contribution is 17% of the cost of simultaneously creating a standard dental prosthesis on one jaw and an implant-supported prosthesis on the other jaw (code J50).

Personal contribution dental prosthesis
You are entitled to reimbursement of the cost of a dental prosthesis for the upper and/or lower jaw. This is subject to a personal contribution. The personal contribution also applies to the cost of placing the fixed part of the supra structure (meso structure). A meso structure is the non-removable construction between implants and the dentures (the click system). The costs of extracting teeth and molars are not eligible for reimbursement, but may be reimbursed if you have a supplementary dental or other cover.
Please refer to Article 31.2 for an implant for a full dental prosthesis if you have a severely lapsed toothless jaw.

Please note
In addition to a personal contribution, an excess may apply.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental implantologist or dental prosthodontist.

Approval

1. You require our prior approval for a conventional (regular) dental prosthesis:
   a. if the total cost (including the technology expenses) of the dental prosthesis exceeds:
   - €675 for an upper or lower jaw;
   - €1,350 for an upper and lower jaw jointly;
   b. if you want to replace your dental prosthesis within 5 years of acquiring them;
2. You require our prior approval for:
   a. dental prosthesis on implants;
   b. rebasing (filling) or repairing dental prosthesis on implants;
   c. a bar or buttons (meso structure).

Please find more information about applying for approval in Article 1.9 of these conditions.

Pharmaceutical Care

Article 34 Medications

This is your cover
Your right to pharmaceutical care comprises delivery of medications or advice and counselling as pharmacists generally offer for medication assessment and responsible use of medications.
This care also comprises:
- issuing a drug subject to prescription;
- issuing a drug subject to prescription with an instruction talk if the drug is new to you;
- instructions for a medical aid to be used for a drug subject to prescription;
- medication assessment of chronic use of medications subject to prescription.

Registered medications
You are entitled to medications prescribed under the Healthcare Insurance Regulation and registered drugs and medications. These are set out in Appendices 1 and 2 of the Healthcare Insurance Scheme.

Preferred medications
Appendix 1 of the Healthcare Insurance Regulation Scheme out groups of medications with the same active ingredient. We select certain active ingredients and a preferred medication. You are only entitled to such preferred medications. Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website. We do not reimburse any other medications with the same active ingredient. In certain rare cases, treatment with a preferred medication is not medically safe and your doctor will state 'medical necessity' on the prescription. In such cases, you are entitled to a different medication.

Medical necessity
Your doctor may only state 'medical necessity' on the prescription if he/she can substantiate the reason. If the pharmacist has doubts about the medical necessity, for example because you have not used the medication before, the pharmacist will contact your doctor. If your doctor's explanation shows that there is a medical necessity, you are entitled to alternative medication. Your pharmacist will select the active ingredient prescribed by your doctor based on your doctor's explanation of the medication he/she recommends for you. This may concern different generic medication. In some cases, the pharmacist may decide on giving you the preferred medication if there is no medical necessity for an alternative product.

Preferred medications and your excess
The excess does not apply for preferred medication. Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website. The excess does apply to pharmacy services. This may include the fees for supplying a medication and assistance regarding the use of new medications. If you use a medication other than the preferred medication due to medical necessity, the excess applies.

Self-care medications
You are entitled to self-care medications if you are to use such medications for a period longer than 6 months. You are only entitled to laxatives, calcium tablets, anti-allergy substances, anti-diarrhea substances, substances for emptying your stomach and substances against dry eyes that are included in Appendix 1 of the Healthcare Insurance Scheme. In the first 15 days, the cost of the medications is charged to you.

Non-registered medications
You are entitled to non-registered medications in the event of rational pharmaco therapy. Rational pharmaco therapy is treatment, prevention or diagnostics of a condition with a drug in a form suitable for you of which the effectiveness and action are determined based on scientific research and testing, and which is also the most economical for the healthcare policy.
You are entitled to the following non-registered medications:
- pharmacy preparations;
- medications that your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medications Act;
- medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you. You are only entitled to such medications if you have a rare condition with an incidence of less than 1 in 150,000 in the Netherlands.

Temporary shortage of medication

If a registered medication cannot be supplied in the Netherlands at all or not in sufficient quantities, you are entitled to an alternative medication from a different country. This medication must be imported from abroad with prior permission of the Healthcare Sector Inspectorate or based on temporary permit issued by the Drugs Assessment Council.

You are not entitled to:

- pharmaceutical care relating to a medication not covered by insurance;
- education on pharmaceutical self-management for a patient group;
- advice pharmaceutical self-care;
- advice use of medications subject to prescription during travel;
- advice risk of disease when travelling;
- pharmaceutical care in the cases indicated in the Healthcare Insurance Scheme;
- preventive travel kit of medications and vaccinations;
- medications for research as referred to in Section 40, third subsection, under b, of the Wet op de geneesmiddelen (Medications Act);
- medications that are equivalent or virtually equivalent to a registered medication not on the preferred list of the Minister of Health, Welfare and Sport;
- medications as referred to in Section 40, third subsection, under e, of the Medicines Act;
- medications for treatment of one or more indications that have been excluded by the Healthcare Insurance Scheme; please find the full Healthcare Insurance Scheme on our website.

Please note:

Pharmaceutical counselling during hospitalisation, day treatment or polyclinic visits and pharmaceutical counselling in the context of discharge from hospital are reimbursed exclusively as part of specialist medical care.

Personal contribution

Some medications are subject to a statutory personal contribution.
Your statutory personal contribution amounts to a maximum of €250 per calendar year.

If your healthcare policy does not start or end on 1 January, we calculate the personal contribution as follows:

$$\text{Personal contribution} \times \frac{\text{number of days that the healthcare policy was effective}}{\text{the number of days in the relevant calendar year}}$$

This amount will be rounded off to the nearest whole euro.

> **Personal contribution medications**
> The Minister of Health, Welfare and Sport determines which medications are covered by the Health Insurance Act and which medications are subject to a personal contribution. Your maximum personal contribution amounts to €250 per calendar year. In addition to a personal contribution, an excess may apply. For more information, please check our website.

Excess

This healthcare is set off against the excess. Do you use preferred medications as set out in the Pharmaceutical Care Regulations? Then the excess does not apply. The excess also does not apply to the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar as they supply the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. You may also choose other lung medication that is not preferred by us. But this is subject to your statutory and voluntary excess.

Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your excess.
For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

Pharmacist or dispensing general practitioner.

Prescription

General practitioner, obstetrician, dentist, orthodontist, medical specialist or a dental surgeon.

Approval

1. You require our prior approval for a number of registered medications included in Appendix 2 of the Healthcare Insurance Scheme. Please find a list of such medications in the Pharmaceutical Care Regulations. We reserve the right to amend the list of preferred medications at any time. You will be notified accordingly. To apply for approval, your doctor may download and complete a doctor's statement from www.znformulieren.nl or an approval form from our website.
   If you selected a pharmacist or dispensing general practitioner that we have contracted for the relevant care, then you can hand in the form completed by your doctor with the prescription. Your pharmacist assesses your compliance with the conditions. If you do not wish to submit the form directly to your pharmacy for privacy reasons, you may choose to directly send or have sent the form to us.
   If you selected a pharmacist or dispensing general practitioner that we have not contracted for the relevant care, you should request prior approval by submitting the doctor's statement to us directly. The address is available in the first section of the conditions and from our website.
2. You require our prior approval for the following non-registered medications:
   - a number of pharmacy preparations (custom medication) supplied. These are preparations your pharmacy makes and delivers to your pharmacy;
   - medications that your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medications Act;
   - medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you.

   Please find more information about applying for approval in Article 1.9 of these conditions.

Contraceptives

If you are under age 21, you are entitled to reimbursement of the cost of contraceptives, including the contraceptive pill, a contraceptive rod, diaphragm, ring or cervical cap. Some items are subject to a personal contribution.

If you are age 21 and up, you are only entitled to reimbursement of the cost of contraceptives if these items are used to treat endometriosis or menorrhagia (if suffering from anaemia). If you are not entitled to such reimbursement, you may be reimbursed for the cost of the contraceptive if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

Irrespective of your age, you are entitled to reimbursement of the cost of having a contraceptive such as a diaphragm or implanon rod placed or removed by a general practitioner or by a medical specialist. For placing or removing a diaphragm, you may also choose an obstetrician certified for this service.

Article 35 Dietary preparations

This is your cover

You are entitled to reimbursement of the cost of polymeric, oligomeric, monomeric and modular dietary preparations. You are only entitled to reimbursement of the cost of such dietary preparations if adjusted regular nutrition and other special nutrition products are not working for you, and you are:

a. suffering from a digestive disorder;
b. suffering from a food allergy;
c. suffering from a resorption disorder;
d. suffering from disease-related malnutrition or risk of malnutrition as indicated based on a validated screening instrument; or
e. you are reliant on this product in accordance with the guidelines accepted by the relevant professional groups in the Netherlands.

Dietary preparations
Diet preparations are medical food with a different form and formula than standard food. There are various types, including liquid nutrition and catheter-administered nutrition.
Liquid nutrition may include extra energy, protein, fat or vitamins and minerals.
Catheter-administered nutrition (tube feeding) is special nutrition directly taken into your stomach or digestive system via a thin tube (catheter) through the nose or abdominal cavity.

Dietary product
A dietary product is a nutrition product with an adjusted formula. Examples are gluten-free or low-sodium products. We do not refund such products.

Excess
This healthcare is set off against the excess. The Pharmaceutical Care Regulations set out a list of preferred products for liquid nutrition, puddings and custards with various flavours. The excess does not apply to such preferred products. You may also choose alternative products. Then the excess does apply. Please find the Pharmaceutical Care Regulations on our website. We reserve the right to amend the list of preferred products at any time. For more information about excess, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A pharmacist, dispensing general practitioner or a preferred healthcare provider. You can only obtain tube feeding from a medical specialist, or facilitating company.

Please note
If you are buying a dietary preparation in a general store such as a supermarket or chemist, you are not entitled to reimbursement.

Approval
You require our prior approval.
If you selected a healthcare provider that we have contracted for the relevant care, you may submit the prescription issued by your doctor or the Dietary preparations statement completed by your dietician (ZN Statement Polymer, oligomer or modular dietary preparations) to the contracted healthcare provider. Your healthcare provider will assess your compliance with the conditions. If you selected a healthcare provider we have not contracted for the relevant care, or you do not want to submit the prescription or statement to your healthcare provider, then you may request prior approval by sending or having sent us the Dietary Preparations Statement directly. The address is available in the first section of the conditions and from our website.

Medical Aids

Article 36 Medical aids and bandaging

This is your cover

You are entitled to reimbursement of the cost of functional medical aids and bandaging as set out in the Healthcare Insurance Decree and the Healthcare Insurance Scheme. In the Medical Aids Regulations we set out further conditions for obtaining such medical aids. The Healthcare Insurance Decree, the Healthcare Insurance Scheme and the Medical Aids Regulations are available from our website. Certain groups of medical aids are included in the Healthcare Insurance Scheme with a functional description. This means that the healthcare insurer can determine which medical aids are covered in the Medical Aids Regulations. If you want a medical aid that is part of the group of functional descriptions of medical aids, but the specific medical aid is not included in the Medical Aids Regulations, you may submit an application form to us.

Most medical aids and bandaging are given to you under direct ownership. If you receive a medical aid as such, you simply own the medical aid permanently. In derogation of reimbursement of the cost you paid, we may provide some medical aids under a lease contract. Lease means that you may use the medical aid as long as you need and as long as you remain insured with us. You can conclude a lease contract with us or with the healthcare provider. This contract sets out your rights and obligations. Leased medical aids can only be obtained from a contracted healthcare provider.

The following information is available from the Medical Aids Regulations:

- whether you are entitled to reimbursement of the cost of the medical aid you will lease or own;
- the quality standards the healthcare provider must meet;
- whether or not you require a referral, and, if yes, who issues it;
- if you require our prior approval (for first procurement, repeat or repair); term of use of the relevant medical aid. This term of use is indicative. If required, you may ask us to deviate from it;
- maximum number of pieces to be delivered. Such numbers are indicative. If required, you may ask us to deviate from it;
- specific details such as maximum reimbursements or statutory personal contributions.

You will receive the medical aids ready for use. If applicable, you receive the medical aid including the first batteries, chargers and/or user instructions.

Information relating to contracted healthcare providers

We make agreements with healthcare providers on quality, price and service. If you selected a healthcare provider that we have contracted for the relevant care, you may expect a quality product and excellent service. Also, you do not need to apply for approval or advance any amounts. We will pay the healthcare provider directly.

Personal contribution/maximum reimbursement

The Medical Aids Regulations set out the statutory personal contribution or maximum reimbursements for the relevant medical aids.

Excess

This healthcare is set off against the excess. The excess does not apply to medical aids on a lease basis. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A healthcare provider for medical aids. The Medical Aids Regulations specify if this healthcare provider must meet certain quality standards.

Lease

If you selected a healthcare provider that we have not contracted for the relevant care, and it concerns leased equipment issued to you based on the Medical Aids Regulations, then please take into consideration that you will likely have to pay part of the bill yourself. In that case, you are entitled to reimbursement of the average cost per user per year. The amount of the average cost is equivalent to the costs we would have paid for providing a leased medical aid.

Referral letter required from

The Medical Aids Regulations set out which medical aids require a referral. This referral letter must include the indication.

Approval

The Medical Aids Regulations set out which medical aids require prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

Extra information

1. Take good care of the medical aid. Within the normal average term of use, you will receive approval for replacement of a medical aid only if the current medical aid is no longer adequate. You may submit an application for replacement within the term of use, modification or repair to us with a motivation.
2. You may obtain approval for reimbursement of the cost of a second piece of the medical aid if you are reasonably relying on it.
3. Leased medical aids may be subject to inspection. If, in our opinion, you are not or no longer reasonably relying on the medical aid, we may claim the medical aid from you.

Stay in an institution

Article 37 Stay

This is your cover
You are entitled to reimbursement of the cost of hospitalisation for 24 hours or longer if due to medical necessity in connection with general practitioner care (Article 11), obstetric care (Article 14.1), specialist medical care (Articles 15 through 22), specialist mental healthcare (Article 25) and specialist dental surgery (oral care, Articles 31 and 32), as set out in these policy conditions, during an uninterrupted period of no more than 3 years (1095 days) as set out in Article 2.12 of the Healthcare Insurance Decree. A stay also includes the necessary nursing, care and paramedical care. Stay is also possible for insured under age 18 who require intensive childcare as set out in Article 13, Nursing and care.

Interruptions of no more than thirty days are not regarded as interruptions, but these days do not count towards the calculation of the 3-year (1095-day) period. Interruptions for weekend and holiday leave do count towards the calculation of the 3-year period.

Excess
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
The stay may take place in a hospital, in a psychiatric ward of a hospital, in a GGZ mental healthcare institution, or in a recovery/rehabilitation institution.
First-line stay is permitted in an institution performing medical care under the responsibility of the general practitioner, geriatric medical specialist or doctor for mentally disabled.
The stay related to intensive child care may take place in a children's care home.

Subject to prescription by
General practitioner, obstetrician, medical specialist, psychiatrist or dental surgeon. For the stay related to intensive child care, a paediatrician or paediatric nurse, level 5, may provide a prescription.
They determine whether stay is medically necessary in connection with the medical care or is medically necessary in connection with surgical help of a specialist nature as set out in Article 31, Dental surgery for insured persons age 18 and older.

Approval
You will need prior approval for stays in connection with specialist medical care (Article 15), rehabilitation (Article 16.1), plastic and/or reconstructive surgery (Article 20), specialist GGZ (Article 25) and oral care (Articles 31 and 32) if this is indicated in the relevant healthcare provision. For more information, please refer to the relevant healthcare article.

Transport of the Patient

Article 38 Transport by ambulance and seated transport of the patient

This is your cover

You are entitled to:

1. transport by ambulance due to medical necessity as referred to in Section 1, first subsection, of the Tijdelijke Wet ambulancezorg (Temporary Ambulance Healthcare Act), over a distance of no more than 200 km, single journey:
   a. to a healthcare provider or institution for healthcare of which the cost is fully or partially covered under the healthcare insurance policy;
   b. to an institution where you will stay with the costs fully or partially covered pursuant to the Wlz;
   c. if you are under age 18, to a healthcare provider or institution where you will receive mental healthcare, of which the cost is fully or partially covered under the competent Municipal Executive pursuant to the Youth Act;
   d. from a Wlz institution as set out in this article under item 1b, to:
      - a healthcare provider or institution for examination or treatment that is fully or partially covered by the Wlz;
      - a healthcare provider or institution for measuring and fitting a prosthesis that is fully or partially covered by the Wlz;
   e. to your home or a different residence if your home does not reasonably allow for the required healthcare if you come back from one of the healthcare providers or institutions as referred to in this article under items 1a through 1d;
2. seated transport of the patient over a distance of no more than 200 km, single journey. Seated transport of the patient includes transport of the patient by car, other than by ambulance, or transport in the lowest class of a means of public transport to and from a healthcare provider or institution as referred to under item 1a, 1b or 1d, or a home as referred to under item 1e.
   You are exclusively entitled to such transport in the following situations:
   a. for kidney dialyses and for the visits, tests and check-ups necessary for treatment;
   b. for oncology treatments with chemotherapy, immunotherapy or radiotherapy and for the visits, tests and check-ups necessary for treatment;
   c. if you are only able to move about in a wheelchair;
   d. your vision is restricted to such an extent that you are not able to move about without assistance.

When are you eligible for seated transport of the patient based on a visual impairment?

Your visual impairment must be such that you are not capable of travelling by public transport. This is determined by your visus (how sharp you can see) and your visual field (angle of your vision). You are entitled to seated patient transport if the visus in both your eyes is below 0.1 or if your visual field is impaired to less than 20 degrees. Some people have a combination of low visus and a very serious visual field impairment. In such cases, individual assessments are required to assess your right to reimbursement of the cost of transport.

   e. If you are under age 18 and you rely on nursing and care due to complex somatic problems or due to a physical disability, with a need of permanent supervision or the availability of 24/7 care in the vicinity (intensive paediatric care);
   f. If, in connection with the treatment of a long-term illness or disorder, you must rely on transport for a long period of time and not supplying or reimbursing this transport would be predominantly unfair to you (hardship clause). This also includes seated patient transport for visits, tests and check-ups necessary for treatment.

When may you apply for a hardship clause?

If the outcome of the sum 'number of consecutive months that transport is necessary X number of times per week X number of km, single journey' exceeds or is equal to 250. For instance: you had to go to hospital twice per week for 5 months. The single journey was 25 km. In this case you may apply for the hardship clause, as 5 months x 2 times per week x 25 km single journey makes 250.

The transport of the patient as included in this article also includes the transport of someone assisting the patient if assistance is necessary or if the patient is under the age of 16. In special cases we may allow for transportation of 2 assistants.

Personal contribution

You are charged a statutory personal contribution amounting to a maximum of €103 per calendar year for seated transport of the patient. This is not subject to a personal contribution.

Excess

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. For ambulance transport: a licensed ambulance transporter.
2. Relating to seated patient transport:
   - taxi driver/firm
   - public transport company. Reimbursement is based on public transport pass, 2nd class
   - private transportation using a private car, of yourself or family care providers (family members, people from the immediate environment): reimbursement of €0.30 per km. The distance is calculated based on the quickest route as provided by the ANWB route planner. The two single journeys (there and return) are calculated separately.

Subject to prescription by

General practitioner or medical specialist. Seated transport of a patient as stated in item 2e (intensive paediatric care) is subject to prescription of the paediatrician or paediatric nurse, level 5.
Transport by ambulance in cases of emergency is not subject to prescriptions.

Approval

You require our prior approval for seated patient transport. You may request approval using the form Medical Declaration for Seated Transport of the Patient. This form is available from our website.
Approval for seated transport of a patient for kidney dialysis and oncological treatments with chemotherapy, immunotherapy or radiotherapy can also be requested by telephone via the transportation desk. The approval for seated transport of a patient for intensive paediatric care as set out in item 2e to and from a children's nursing care centre or children's care home can also be requested by telephone via the transportation desk. The telephone number is available from the transportation desk on our website.

Extra information

1. If we grant you approval to go to a certain healthcare provider or institution, the 200-km limitation does not apply.
2. In cases where transport of the patient by ambulance, car or a public means of transport is not possible, we may allow the transport of the patient to take place by another means of transport to be designated by us.

Healthcare Mediation

Article 39 Healthcare advice and mediation

This is your cover

You are entitled to mediation for care in the event of a non-acceptable long waiting time for treatment by a healthcare provider who may provide this care according to this healthcare insurance policy. You may use the services of our Healthcare Advice and Mediation department (afdeling Zorgadvies en Bemiddeling) for such mediation services. You can reach this department through our website.

You may also approach this department for general questions on care, such as relating to looking for a healthcare provider with a certain area of expertise or help in navigating through the care sector. We will be happy to review the options with you.

III Definitions

Acute healthcare: Unforeseen care that cannot reasonably be postponed. Acute healthcare is also referred to as emergency care. If it concerns healthcare provided abroad, then acute healthcare also includes any healthcare that cannot reasonably be postponed until your return home.

CAK: Centraal Administratie Kantoor (CAK - Central Administrative Bureau).

Group contract: A group contract for healthcare insurance (group contract), concluded between the healthcare insurer and an employer or legal entity, aiming to offer the associated participants the option of closing a healthcare insurance policy and any supplementary insurance policies as set out in this contract.

Diagnosis Treatment Combination (DBC): A DBC is based on a DBC code issued by the Nederlandse Zorgautoriteit (NZa or Netherlands Healthcare Authority), describing the completed and validated process of specialist medical care and specialist GGZ (mental healthcare) (second-line curative GGZ). This includes part of the care process or the full care process of the diagnosis as made by the healthcare provider up to the ensuing treatment (if any).
The DBC regimen begins at the moment that the insured person registers with the care need, and ends at the end of the treatment or after 120 days for medical specialist care and after 365 days for specialist mental healthcare.

Personal contribution: A fixed amount/share of (reimbursement of the costs of) care referred to in these policy conditions that you yourself must pay before becoming entitled to (reimbursement of the cost of) the remaining part of the healthcare.

Excess
1. Statutory excess: an amount towards the costs of care or other services as set out in or pursuant to Section 11 of the Healthcare Insurance Act, which is payable by you;
2. Voluntary excess: an amount towards the costs of healthcare or other services as agreed between you, as the policy holder, and the healthcare insurer, as set out in or pursuant to Section 11 of the Zvw (Healthcare Insurance Activities), which is payable by you.

European Union and EEA Member State: includes the following countries other than the Netherlands in the European Union: Austria, Belgium, Bulgaria, Croatia Cyprus (the Greek area), the Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Martinique, St. Barthélemy, St. Martin and La Réunion), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal (including Madeira and the Azores), Romania, Slovakia, Slovenia, Spain (including Ceuta, Mellilla and the Canaries), Sweden and the United Kingdom (including Gibraltar). Under convention provisions Switzerland is considered as equivalent to these countries. EEA countries (Member States who are a party to the Agreement on the European Economic Area) are also included: Iceland, Liechtenstein and Norway.

Fraud: the intentional commission or attempted commission of forgery, deception, injuring the rights of debt collectors or beneficiaries and/or misappropriation or embezzlement in the process of entering into and/or performing an insurance contract or healthcare insurance contract, with the objective of obtaining a benefit, reimbursement or performance to which the party is not entitled, or obtaining insurance cover under false pretences.

Birth clinic: First-line birth clinic for facilitating natal care (healthcare during delivery) and postnatal care (healthcare during the first 10 days after delivery), of which the management and operations are performed by healthcare providers of first-line natal healthcare. The management and operations of the first-line birth clinic may also be performed by healthcare providers other than first-line obstetricians, such as maternity care institutions.

GGZ: Mental Healthcare.

GGZ Institution: An institution providing medical care pertaining to a psychiatric condition, and that is licensed as such under the WTZi (Care Institutions Accreditation Act).

GGR (Weight-Related Health Risk): The GGR indicates to what extent the person has an increased health risk. This factor is based on the BMI (Body Mass Index) in combination with the presence of risk factors for a certain condition or existing conditions.

Institution
1. An institution as referred to in the Wet toelating zorginstellingen (Care Institutions Accreditation Act);
2. A legal entity with its primary place of business abroad providing care in the country concerned according to the social security system existing in that country or which is aimed at providing care to specific groups of public officials.

KNMG: the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG - Royal Dutch Company to Promote Medicine) is a federation of professional associations of medical doctors and the association The Medical Student, and represents the interests of doctors in the Netherlands.

NZa: Nederlandse zorgautoriteit - Dutch Healthcare Authorities.

In writing: where the policy conditions refer to 'in writing', this also includes 'by email'.

Permission (authorisation): Approval in writing for receiving certain care provided to you by or on behalf of the healthcare insurer, prior to receiving the relevant healthcare service.

You: Policyholder and/or insured.

Stay: A stay of 24 hours or longer.

Treaty country: A country not being a Member State of the European Union or the EEA, with which the Netherlands has entered into a social security convention including provisions for rendering medical care. This includes the following countries: Australia (for holidays/temporary stay), Bosnia-Herzegovina, Cape Verde Islands, Macedonia, Morocco, Serbia-Montenegro, Tunisia and Turkey.

Insured: A person whose risk of needing medical care as referred to in the Healthcare Insurance Act is covered by a healthcare insurance policy and who is stated as such on the policy cover as issued by the healthcare insurer.

Policyholder: The person who concluded an insurance contract with the healthcare insurer. These policy conditions refer to the policyholder and the insured as 'you'. Provisions referring only to the policyholder specifically state this in the relevant article.

Person subject to statutory insurance: A person who is subject to mandatory insurance pursuant to the Healthcare Insurance Act; the person must take out a healthcare insurance or have this taken out.

Policy Conditions VGZ Eigen Keuze /policy conditions: The healthcare insurer's model contract as referred to in Section 1j of the Healthcare Insurance Act.

VGZ Eigen Keuze: A healthcare insurance policy taken out by the policyholder with the healthcare insurer for a person subject to statutory insurance. These policy conditions refer to the VGZ Eigen Keuze as 'the healthcare insurance'.

Wlz: Long-Term Healthcare Act.

Wmg rates: Rates as determined pursuant to the Market Regulation Healthcare Act (Wmg Act).

Hospital: An institution for specialist medical care that is accepted in accordance with the Wet toelating zorginstellingen (WTZi or Care Institutions Accreditation Act). Hospital stays of 24 hours or longer are covered.

Healthcare: Care, healthcare or other services.

Healthcare provider: The natural person or legal entity providing healthcare professionally as set out in Section 1, preamble and subsection c, part 1 of the Wmg. Healthcare provider also includes all treatment professionals who are involved in delivering healthcare at the healthcare provider's risk and expense.

Healthcare provision: Provision relating to certain healthcare. See Section II, Healthcare Provisions.

Healthcare Policy: The instrument in which the healthcare insurance taken out by the policyholder with the healthcare insurer is laid down. The healthcare policy consists of a policy cover and these policy conditions.

Healthcare insurer/VGZ: VGZ Zorgverzekeraar N.V., with its registered office in Arnhem, Chamber of Commerce number: 09156723. The healthcare insurer is registered in the Insurers Register of AFM (Financial Markets Authorities Netherlands) and DNB (the Dutch Central Bank), licence number: 12000666. The healthcare insurer is part of Coöperatie VGZ U.A.
The healthcare insurer is referred to as 'we' and 'our' in these policy conditions.

Healthcare insurance policy: A non-life insurance or healthcare non-life insurance contract concluded between a healthcare insurer and a policyholder for a person subject to mandatory insurance as set out in Section 1 subsection d of the Healthcare Insurance Act, of which these conditions form an integral, inseparable part.